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ABSTRACT

This study was undertaken as a means to explore whether or not a counselling service had a role to play in the reduction of stress in the National Health Service (NHS). Current literature and anecdotal evidence would suggest that stress has increased in the NHS particularly following the Governments health reforms. The thesis considers how far this is the case and whether stress has increased following the changes in organisational structure and practice. There is now a substantial and well established literature on stress at work which relates to the NHS. This suggests that stress interferes with performance and that in turn can affect the performance of the organisation. The cost of this stress both on the individual and the organisation was examined. Strategies that the individual may initiate to reduce stress and strategies the organisation could initiate to reduce stress in the work force were also examined. This examination included the role of a counselling service.

These issues were explored through the literature and by means of a small qualitative study involving nurses working in a middle management role in a NHS Trust. From these sources conclusions were drawn regarding the causes and effects of stress for that particular group and ways in which stress could be managed both individually and organisationally. What was clear from the data was that a counselling service alone may not assist in the reduction of stress. There seemed two main reasons for this. Firstly counselling addresses individual symptoms rather than organisational causes unless some system of feed back to the organisation is built into the process. Secondly there was a reluctance of employees to use a counselling service. This reluctance to use the service was due to a resistance to admit to feelings of stress particularly associated with work. The organisational culture somehow perceived this as a weakness. It is this aspect that warrants further examination and exploration if indeed the NHS wishes to create a healthy work environment.

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INTRODUCTION

Stress has probably always been a major hazard of organisational life. However, it is only relatively recently that this condition has been recognised in terms of its enormous potential for both personal and organisational damage. A substantial and well established quantity of literature now exists in relation to stress, such as the works of Sutherland and Cooper (1991), Ross and Altmaier (1994) and Marshall and Cooper (1981).

Stress has been blamed as a major cause of ill health and sickness absenteeism at work. It is estimated that stress-related illnesses account for 40 million working days lost each year in the United Kingdom (Powell and Enright 1990). According to the Health and Safety Executive between 30% and 40% of all sickness absence from work can be attributed to some form of mental disturbance (Lucas 1989). Lucas points out that the vast majority of cases are mild and capable of being treated within the community or work setting. Often however, a large number of people go unrecognised and untreated becoming as Lucas calls them "the working wounded". It is likely that these "working wounded" could include many individuals suffering from stress.

The National Health Service (NHS) is the largest employer in Britain and there is a growing body of evidence to suggest that because of the nature of their work, health employees are particularly susceptible to stress related illnesses (Payne and Firth-Cozens 1987, Rees and Cooper 1990, Smith 1992). Findings such as these suggest that a substantial number of NHS staff in all levels of the

workforce do experience stress as a result of their work. Such stress arises from a number of different factors which can include the nature of the work e.g., the demands of caring for physically and emotionally disturbed people (Smith 1992), characteristics of the job such as shifts and unsocial hours and the personal and domestic difficulties of the individuals themselves and the ways in which work is organised and carried out i.e. the administration and structure (Owen 1993).

This notion that the structure and climate of an organisation can engender stress was also suggested by Cooper et al (1988). The NHS appears to be a good example of such an organisation whose structure may indeed create stress for employees. Apart from the afore mentioned above that have been deemed to create stress, there have been major managerial and structural changes imposed on the organisation in a relatively short time span. It is approximately 12 years between the Griffiths Report in 1983 and the current NHS reforms. Work in the NHS can be sub-divided into that of direct client/patient care and that of managerial/support activities. It is in the former area that most research has been located. However, each sub-division contributes to the goals of the organisation which is the business of promoting health, curing disease and alleviating suffering. Doctors, nurses and other health care workers are daily confronted with human pain and trauma and have to deal with their emotions and feelings about their patients, as well as their own ability to deliver the appropriate care. Similarly those who manage the organisation, who may not have direct patient contact are also aware that their decisions concerning the resource management have an impact on those

patients. They have to balance the demand for health care within a limited budget , this must be a difficult equation to manage.

My experience in the NHS is that of nursing and nurse education. When I transferred to nurse education I became more acutely aware of how stress, either at home or at work, could interfere with student nurse performance and progress in both the theoretical and the practical aspects of their education. My colleagues and I found that a proportion of our time was spent supporting students and sometimes trained staff through difficult times. I developed an interest in counselling during this time and pursued some basic counselling training. I found the skills and process involved in counselling particularly useful when helping students and colleagues cope with stressful situations.

Talking to colleagues there appears to be the belief that stress has increased over the past few years. The reasons for this appear vague but seem to be linked with increased technology, leading to increased patient turnover and limited resources. One purpose of this thesis therefore is to ascertain if this is indeed the case. Has stress increased and if so why? In addition, the question is explored whether strategies and services developed by the organisation, including a counselling service could help resolve some of those feelings of stress.

From personal experience, the role of middle manger was quite stressful, as one felt "squeezed" between the policy makers and those at operational level, with no real feeling of belonging to either group. It seemed appropriate therefore to explore stress at work with this group. Two other reasons also

contributed to the choice for focus on this group. Firstly, most research concerning stress is associated with those individuals giving direct client/patient care, rather than those involved in indirect care such as managers. Secondly there have been radical changes following the NHS reforms which some have suggested are contributing to feelings of stress for employees. This particular group of nurses are at the interface between management and the care givers and thus may be experiencing increased stress in light of these changes due to lack of role clarity and "moving" role boundaries in this time of constant change.

Consideration of these issues posed the following questions :

1. What are the factors causing stress at work for nurses working in the NHS, particularly in a middle management role and how does that impact on their work performance?
2. How far is stress aggravated by the organisational structure of the NHS and the recent reforms?
3. How far and in what ways can the NHS as an organisation attempt to reduce stress for its employees?
4. Does a counselling service have an important role in such a strategy?

The task of the thesis is to address these questions. To achieve this the following process will be undertaken. Initially the concept of stress will be explored as a means to arrive at some working definition. This will be followed by an examination of the effects of stress on an individual and how that stress is managed. Factors that cause stress at work and its impact on

work performance will then be examined in the nursing context and whether or not organisational changes following the NHS reforms are contributing to stress. A discussion will then be generated as to the management of that stress by the organisation and the value of counselling in this scenario.

The literature reviewed should allow for some conclusions to be drawn as to the causes, effects of and responses to stress at work for nurses working in a middle management role. However it is recognised that the conclusions drawn will be based mostly on generalisations. Field work will then be undertaken with a group of nurses in a middle management role to ascertain personal perceptions. Following analysis of the data collected, comparisons will be made with these findings and the generalised findings based on the literature to draw final conclusions and suggestions for the way forward.

CHAPTER 1

STRESS AND ITS EFFECT ON THE INDIVIDUAL

The purpose of this chapter is to offer some working definition of stress. This will be followed by an examination of the effects of stress on individuals and how individuals attempt to manage that stress.

DEFINITIONS OF STRESS

Stress has been defined as "any event in which environmental demands, internal demands or both, tax or exceed the adaptive resources of an individual, social system and tissue system". (Farmer, Monohan and Hekeler 1984:13).

This definition seems to suggest that it is the perception by the individual of an event or situation that precipitates a state of stress. This introduces a cognitive element and proposes that individuals will only feel stress if they perceive an event or situation as a threat to themselves. If this is the case, then it is reasonable to assume that stress has different connotations for different people. Situations or stressors will affect individuals differently, dependent upon the perceived threat to them. Stress therefore could result from any kind of event dependent upon individual perception.

Rice (1992) suggests other terms such as pressure and strain could easily be substituted for stress. For example, in engineering, stress is described as one force on another, possibly leading to damage or breakdown of that

system. In human terms this could also be the case. Rice suggests stress has three distinct meanings :

i) Any event or environmental stimulus that causes a person to feel tense, agitated or aroused.

ii) A subjective response caused by an internal mental state, tension or arousal.

iii) The body's physical reaction to demand or damaging intrusions.

Whilst further definitions of stress could be offered and explored, the constraints of this study will not allow for extensive debate. For the purpose of the thesis the definitions offered by Rice (1992) and Farmer et al (1984) will be used as they enable some direction to be followed. Both seem to suggest that when considering stress, the environment causing the demand and the personal responses or adaptions to that demand need to be explored. In this study the environment is that of work, whilst the personal responses and adaptions are the means by which an individual attempts to cope with stress.

It is very difficult when talking about stress to disregard the term anxiety. Both seem interrelated and the terms are often used inter-changeably. Dictionaries tend to describe anxiety as a state of apprehension or uneasiness and stress as some sort of emotional tension. However, stress is a relatively new term and it maybe the usage is dictated by ones age, rather than any clear distinction. For that reason the term stress will be used throughout the thesis based on the discussion above.

From the discussion above it appears that stress can initiate some response in an individual. What are these responses and what initiates them? Literature suggests that stress can affect an individual both physically and psychologically. In the following section this will be explored.

PHYSIOLOGICAL EFFECTS OF STRESS

There are three body systems involved in the response to stress, the hypothalamus, the pituitary and the adrenal glands. The hypothalamus stimulates the pituitary which in turn stimulates the adrenal glands to release hormones, particularly adrenaline. Adrenaline increases systemic activity, (gastric motility, heart rate, respiratory rate). The response is often described as the fight/flight theory in anxiety. Once however the stimulus creating the response has been removed, the body returns to a state of equilibrium. If on the other hand the stimulus is not removed and these systemic changes are prolonged, then physical illness can result leading to diseases such as hypertension, heart attacks and strokes (Selye 1978). Selye found that during periods of stress as well as increased levels of adrenaline, there was a decrease in the size of the lymph glands, making the individual more susceptible to infection and disease, the body defenses being lowered. Farmer et al (1984), propose that stress can lead to both mild or extreme physical symptoms (Table 1). They suggest the extent of the physical symptoms depends on individual differences and the level or length of exposure to stress.

TABLE 1

PHYSICAL SYMPTOMS OF STRESS

MILD	EXTREME
Headaches	Migraine
Gastro-intestinal upset	Colitis
Skin Irritation	Eczema
Susceptibility to infection	Tuberculosis
High Blood Pressure	Heart Attack, Stroke

(Farmer et al 1984)

PSYCHOLOGICAL EFFECTS OF STRESS

Stress can also affect an individual psychologically although often this is not as easily recognised. Psychological responses to stress are much more concerned with our personal perception or experience of a situation, this can vary considerably between individuals especially in less extreme situations. For example, most people would demonstrate some stress response if held hostage but not all would demonstrate that response prior to an examination. Based on the interpretation of the definitions by Farmer et al (1984) and Rice (1992) response depends on the threat that the individual perceives and their ability to cope with it.

Psychological response to stress can often be detected by both behavioural and/or emotional changes. An individual may direct their feelings towards themselves and/or their friends and family in the form of anger, aggression or withdrawal, rather than towards the situation creating that

response. If directed towards themselves it may result in self harm, if directed towards family and friends, a breakdown of relationships. Rice (1992)

Parry (1990), contends that emotional reactions caused by stress affect the way we think and the way we think affects our emotions. According to Parry, high levels of stress colour our judgment making it more likely we believe the frightening thoughts. If we are depressed or low in self esteem our thoughts which match those feelings will carry most weight. If our thought processes are influenced in this way it is unlikely we will be able to "think clearly" about the situation generating those feelings. Parry also suggests that stress, can cause problems with concentration. An individual forgets appointments, or goes off to do a job, is side-tracked and wonders what they are supposed to be doing. This can lead to poor performance, criticism from superiors, loss of self esteem and thus increased levels of stress.

So far it appears that stress is disabling and destructive. However, according to Gardener and Gardener (1990), stress can also be enabling and/or constructive. They propose that some of us work better under stress, using the increased adrenaline as a stimulant to help us complete the task. They do recognise however that if the challenge is too great, then the stress level is no longer enabling and constructive and can become disabling or destructive. This notion is also supported by Al-Assaf (1992) who suggests the stress curve. Up to a certain point performance is improved in direct relationship to the amount of stress. However if stress levels continue to grow, performance and efficiency will decline. Al-Assaf (1992) citing the work of Fraser (1988), and McGorry and Singh (1985), found that this stress curve was specific for each person, reinforcing the individual nature of stress effects.

So, whilst stress affects an individual, not everyone suffers the same effects or to the same degree. There appears to be some other factors which

need to be considered. Cooper et al (1988) provides evidence for some key factors that influence an individual's vulnerability to stress. They include personality, coping strategies, age, sex, ethnic background and social support. They go on to describe the work of Friedman and Rosenman in the 1960s, who identified two personality types, Type A and B.

Type A personality was extremely competitive, aggressive, impatient, restless, always appearing to be under pressure. These individuals were also more prone to coronary heart disease in the form of hypertension and heart attacks. Type B personality on the other hand, was much more relaxed and was less likely to develop coronary heart disease. If the physiological response to stress described earlier can lead to physical illness, then it would seem a person with Type A personality is more at risk from physical illness following prolonged exposure to stress than those of Type B personality. It has generally been accepted that Type A personalities are more likely to be affected by coronary heart disease than those of Type B (Phares 1991)

Age, according to Cooper et al (1988), is also a factor to consider when discussing the effects of stress. As we become older we become more susceptible to the disease process, thus exposure to stress could increase the risk of illness. Until recently men appear to have been more at risk from stress-related illness than women. Women generally live longer. However, with the changing role of woman in society this pattern is also changing. There is now an increased incidence of women suffering from stress related diseases. (Cooper et al 1988 : 68) However the gap in life expectancy is still increasing. Cooper et al (1988) also suggest ethnic minorities have additional problems of stress related to racial prejudice in both social and work settings. This is often exacerbated when their belief systems clash with the majority's attitudes and values.

Coping strategies and social support are other factors which could influence our vulnerability to stress. An individual who has poor coping mechanisms and minimal family or social support, will find it more difficult to meet the demands they encounter. With age, those coping strategies and social support networks could be more developed, helping us cope with stress more easily. However, the opposite could occur. There is more mobility nowadays and as children grow and leave home they are less likely to live near the family home. As parents become elderly, their family support network may in fact reduce. Similarly as one gets older ones peers begin to decline in number due to deaths.

It seems therefore that stress does have some effect on an individual both physically and psychologically. However these effects may not necessarily be harmful. It does appear that some degree of stress is needed to motivate us and improve performance but if that stress is allowed to escalate we may become ill and/or our performance will deteriorate.

Individual Management of Stress

Farmer, Monohan and Hekeler (1984) suggest that as children we learn from our parents and other important adults not only values, but various strategies for coping with stress. Coping refers to the successful responses made by an individual who encounters a situation with a potentially harmful outcome (Meichenbaum and Calman 1983). According to McHaffie (1992), coping is a dynamic process, not necessarily total triumph or surrender but a move towards a compromise, establishing an equilibrium.

Rice (1992), proposes that coping aims at one of two outcomes; to alter the relationship between self and environment or to reduce emotional pain and distress. These outcomes can be achieved through a conscious effort,

whereby the individual recognises they are becoming stressed and take some action to reduce that stress. Alternatively the individual may not acknowledge or be unaware of the stress, but their behaviour changes as a means to cope with that stress. The first approach could be deemed as "healthy" as it aims to promote health and retain the equilibrium. The second approach could be deemed "unhealthy" as sometimes palliative measures are used to reduce the stress such as drugs or food.

Rice (1992) goes on to suggest a coping model which is either preventive or combative. Preventive coping attempts to prevent stress from developing either through cognitive processes that interfere with perception of stress, or through increasing resistance to the effects of stress. Combative coping occurs when stress triggers a reaction. Both these methods suggest some form of interaction between the environment and the person.

An overview of the model proposed by Rice is reproduced here.

TABLE 2 - PREVENTIVE AND COMBATIVE COPING METHODS

PREVENTIVE STRATEGIES	COMBATIVE STRATEGIES
1. Avoiding stressor through life adjustments	1. Monitoring stress and symptoms
2. Adjusting demand levels	2. Marshalling resources
3. Altering stress-inducing behaviour patterns	3. Attacking stressors
	a) Problem solving
	b) Assertiveness
	c) Desensitisation
4. Developing coping resources	
a) Physiological assets	
b) Psychological assets	4. Tolerating stressors
confidence	
self-esteem	
sense of control	a) Cognitive restructuring
c) Cognitive assets	b) Denial
functional assets	c) Sensational focusing
time management	
academic competence	5. Lowering arousal
d) Social assets	
social support	a) Relaxation
friendships	b) Disclosure
e) Financial assets	c) Catharsis
	d) Self-medication

(Taken from Rice 1992 : 271)

Rice suggests that although this model is useful it is dependent upon other factors. Those factors are individual *coping resources, coping behaviours and coping styles*.

Coping resources can either be personal, social or physical and appear to be associated mainly with preventive strategies identified in the model above. According to Rice (1992) our most important personal resource is that of positive self-esteem. Social resources include the networks of friendship

and groups to which we may belong, whilst physical resources relate to health, housing and money.

Coping behaviours can be either positive or negative. The following table identifies the positive coping behaviours suggested by Rice (1992).

Table 3 COPING BEHAVIOURS

1. TENSION REDUCTION
2. COGNITIVE RESTRUCTURING
3. PROBLEM SOLVING
4. SOCIAL SKILLS
5. POSITIVE DIVERSIONS
6. OPEN AND CLOSED SYSTEMS (Letting Out or Holding In)
7. SEEKING INFORMATION
8. STRESS MONITORING

(Rice 1992)

Examining Table 3, positive coping behaviour appears to suggest some form of pro-active behaviour on behalf of the individual. The individual endeavours to actively reduce the cause of stress.

Rice also identifies negative coping behaviour and supports the notion of defense mechanisms proposed by Freud (1946). Hilgarde and Atkinson (1975) citing Freud (1946) suggest individuals may use defense mechanisms as a means to cope with a stressful situation. These mechanisms can be described as negative coping behaviour because whilst providing some short term relief they do not deal with the underlying problem (see Table 4).

TABLE 4

ADAPTIVE ASPECTS OF DEFENCE MECHANISMS

MECHANISM	AS A DEFENCE	AS A METHOD OF COPING
Discrimination : ability to separate ideas from feelings	Intellectualisation : severs ideas from their appropriate emotions	Objectivity : separates ideas from feelings to achieve a rational evaluation or judgment when necessary
Means-end symbolisation : ability to analyse experiences, to anticipate outcomes to entertain alternatives	Rationalisation : offers apparently plausible explanation for behaviour to conceal nature of underlying impulse	Logical analysis : analyses carefully the causal aspects of situations
Selective awareness : ability to focus attention	Denial : refuses to face painful thoughts or feelings	Concentration : temporarily sets aside painful thoughts in order to stick to task at hand
Sensitivity : apprehension of another's unexpressed feelings or ideas	Projection : unrealistically attributes an objectionable tendency of his own to another person instaed of recognising it as part of himself	Empathy : puts himself in the other person's place and appreciates how the other fellow feels
Impulse diversion : ability to modify aim or object to an impluse	Displacement : temporarily and unsuccessfully represses unacceptable impulses. May displace to an inappropriate object	Substitution : finds alternative channels that are socially acceptable and satisfying for expression of primitive impulses
Impulse restraint : ability to control an impulse by inhibiting expressions	Repression : totally inhibits feelings or ideas. Repressed material revealed only symbolically as in dreams	Suppression : holds impulses in abeyance until the proper time and place with the proper objects

(Hilgarde and Atkinson (1975 : 448)

Examining Table 4 we can see that when these mechanisms are used as a defence they can be "self deceptive" not really dealing with the problem in hand. However when used as a method of coping they do give an individual

time to solve a problem, which may otherwise overwhelm them. Whether or not the mechanism is used as defence or as a method of coping is not always distinguishable. It is only by exploring their behaviour with the individual that it would become clear to them that their defensive behaviour will not sort the problem in the long term, only give transient relief. Another means of negative coping is the use of substances, be they food, alcohol or drugs. Whilst initially these substances can give immediate relief they will not deal with the root cause. The long term effects of this behaviour may also be self-defeating, resulting in damage to physical health.

Coping styles, relate to the manner in which an indivdual can deal with a stressful situation. If we find that a particular style has succeeded, in as much it reduced stress, then it is likely we will continue to use that style of coping. Similarly if we accept, as Farmer et al (1984) suggest, that we learn our coping from our parents, then it is likely our coping style will reflect how they dealt with particular problems and crises.

A key element in the use of any coping strategy is the element of personal control. Meichenbaum and Calman (1983), suggest that when an individual believes he/she can exercise some control over a stressful situation, then their level of stress is less. If an individual feels powerless to change a situation which is affecting them, then their stress will increase. Coping styles however do appear to be linked with self-esteem, the extent to which the individual has confidence in themselves and the influence they can have on the situation.

It appears therefore that an individual experiencing stress can call upon coping strategies as a means to reduce that stress. Those strategies can be either preventive or combative. However those strategies themselves appear to be dependent upon other aspects of coping such as the personal traits and

cognitive abilities we bring to a situation. Resources such as problem solving ability requires high cognitive skills such as those of analysis, planning and evaluation. Coping behaviours both positive and negative have a part to play in the reduction of stress. Positive coping behaviour such as developing social support through social skills appears to help in the reduction of stress. (Rice 1992) Similarly the use of negative coping skills will help with short term coping but may not significantly help in the long term. Coping styles and positive self-esteem also assist in the coping process. The perception of our ability to have an influence over a situation, enables us to deal with stressful events more effectively.

Long term coping depends on mature coping skills based on past experience, self esteem and success. However during that coping process there may be a time when the stress level is significantly high to affect performance, or it maybe that the stress encountered exceeds or exhausts the individual's coping resources resulting in ill-health and /or poor performance as suggested by Parry (1990). It is this type of scenario that has implications for the organisation.

The definition of stress given at the beginning of this chapter suggested it was the perception by the individual of an event or situation that precipitated a state of stress and thus different people will be affected by different stressors. It appears to be accepted that working in the NHS, particularly in the medical, para-medical and nursing fields is stressful, by the very nature of the work. This stress has been added to in recent years in some part, by the increase in medical and nursing technology. (Hingley 1984, Health Education Authority 1988, Payne and Firth-Cozens 1987). Most of the research in this area has focused on the stress related to clinical practice.

In light of this, rather than consider stress related purely to the aspect of caring, stress and nursing will be considered in the wider context of the organisation. The classification of the factors associated with stress at work proposed by Cooper et al (1988) will be considered. They concern factors intrinsic to the job, role in the organisation, relationships at work, career developments and organisational structure and climate. The reason for this is that there have been previous studies conducted with different groups of nurses in the NHS which identified factors not directly associated with caring but which seem to address some of the factors proposed by Cooper et al (1988).

Birch (1975), researched the reasons as to why student nurses left the nursing profession. He found most stated they had left because they could not cope with the stress. He identified the areas that appeared to cause most problems, arranging them in rank order. Most appear to be related to threats to self esteem by not knowing what to do, being shown up, and dealing with relationships with senior staff. Birch's work was echoed a decade later by Fretwell (1982 and 1985), who was researching what interfered with learning in the clinical area sufficiently to impede performance. Her identified stress areas were similar to those identified by Birch and occurred in a similar rank order (See Table 5.1 and 5.2)

TABLE 5.1

Rank/Stress Area
1 Changing wards
2 Knowing what to do
3 Being shown up on the wards in front of patients and other staff
4 Understaffing
5 Dealing with bereaved relatives
6 Dealing with nursing officers
7 Nursing of patients with great pain
8 Dealing with doctors
9 Dealing with patients with Cardiac Arrest
10 Differing procedures in classroom and wards
11 Availability of study time
12 Dealing with patients with cancer
13 Care of dying and terminally ill
14 Your own progress report by Ward Sister
15 Carry out procedures before being taught at school
16 Dealing with sputum
17 Dealing with relatives
18 Dealing with tutors
19 Use of telephone for communications
20 Your feelings of your own death

(Birch 1975)

TABLE 5.2

Rank/Stress Area
1 Changing wards
2 Dealing with bereaved relative
3 Understaffing
4 Dealing with patients with Cardiac Arrest
5 Being shown up on the wards in front of patients and other staff
6 Dealing with doctors
7 Availability of study time
8 Knowing what to do
9 Dealing with nursing officers
10 Nursing of patients in great pain
11 Carrying out procedures before being taught in school
12 Care of the dying and terminally ill
13 Dealing with relatives
14 Use of telephone for communications
15 Your own progress reports by Ward Sister
16 Differing procedures in classroom and wards
17 Dealing with patients with cancer

(Fretwell 1985)

Whilst there are some differences in the ranking order of the stress areas there are many similarities. The differences are not easy to explain. For example dealing with bereaved relatives ranks 2 with Fretwell's work but 5 with that of Birch. The nursing curriculum contained more preparation for dealing with bereavement in 1985 than at the time of Birch's work in 1975 but instead of decreasing stress it appears to have increased it! However it is reassuring, from a nurse education perspective, that the factor of procedures being taught in the classroom which differed from those seen in the ward is reported as less stressful in the later study. One could presume that classroom teaching is now more in keeping with reality.

The work of both Birch and Fretwell involved only nurses in training and mainly concerns "factors intrinsic to the job" (Cooper et al 1988) such as nursing patients in pain, care of the dying and dealing with relatives. The other stress areas could be broadly categorised under "relationships at work" (Cooper et al 1988). The students involved in these studies were relatively few in number with limited nursing experience, and this may account for only 2 of Cooper et al's classifications being evident.

It is not the purpose here to analyse in detail the reasons for similarities and differences in both studies. However in both studies stress was high enough to result in students leaving the profession or intefere with their learning and performance. In the work of Birch most students left nurse training in the first 18 months. He suggested measures to reduce this including better selection procedures to ensure individuals with a "suitable personality" would be recruited. Did he mean by this those personalities who could find it easier to cope with stress as suggested by Friedman and Rosenman in the 1960s and cited by Cooper et al (1988)? He also recommended better preparation for students for certain experiences and more effective appraisal by qualified staff of student performance. Fretwell's (1988)

work identified the Ward Sister as the key individual in creating an environment in which students could learn, one which was supportive and encouraging. However to do this Fretwell suggested the ward needed preparation. What Fretwell did discover incidental to the research was that stress was found to be a hidden barrier to change. If one accepts this notion then it is likely that the stress experienced by nurses could intefere with their ability to meet the changes incurred with the recent NHS reforms.

Further studies by Hingley and Harris (1986) and Bamber (1991) on the causes of work stress in nursing, also reflect the factors suggested by Cooper et al (1988). This time all factors were identified but work overload, career prospects and lack of involvement in the decision making process were the main causes of stress. All the studies mentioned so far used different groups of nurses, the latter group being nurse teachers, but areas mentioned could be categorised in the areas proposed by Cooper et al (1988). For that reason these factors will be considered in this study as a means to explore stress at work for nurses. It allows stress and nursing to be considered in the wider context of the organisation and not purely related to the aspect of caring.

CHAPTER 2

CAUSES OF STRESS AT WORK

The purpose of this chapter is to explore the factors that could create stress at work utilising Cooper et al's (1988) classification. Whilst those studies mentioned in the previous chapter do seem to reflect the appropriateness of this classification it is recognised that any classification does have limitations when applied to different areas.

Quick, et al (1993) suggest that "a person's work and occupational stature may play an important role in an individual's sense of identity self esteem and psychological well-being" For most individuals work is a central defining characteristic of life. However it appears that this "central and defining characteristic of life" can also be a major contributor of ill-health by its ability to create stress. Each factor identified by Cooper et al (1988) will be explored in relation to nursing, particularly for those nurses working in middle management roles.

Factors Intrinsic To The Job

Within this area Cooper et al (1988) identifies aspects such as working conditions, new technology, shift work, long hours, travel, risk and danger, work overload and underload.

Working Conditions

Working conditions associated with the environment in nursing appear to have improved dramatically. Many old fashioned, Victorian styles of building have been replaced with new larger District Hospitals giving more space and an apparently improved environment. However, lighting in these buildings is usually harsh and artificial which researchers have found can become stressful over a period of time (Cooper et al 1988 : 87). The areas usually affected are those areas where there is no natural daylight, such as Intensive Therapy Units and Operating Theatres. These areas by their very nature are already considered stressful areas to work in because of the nature of their work. Nurses managing these areas, although not totally based in the department, do spend considerable time there and equally could be affected.

Technology

The use of technology within nursing generally has increased over the years. Keeping up with this new technology can in itself be a source of work stress, especially for the nurse returning after a period of absence following child rearing or illness. Copp (1988) citing Tschudin (1985), suggested increasing technology as a source of work stress amongst nurses. She argued that factors such as this led to resentment, resistance and insecurity. Nurses in management may feel even more threatened by increased technology if they are not directly using it, but believe the staff expect them to have the appropriate skills and knowledge because of their role. Their experience with technology may be more concerned with Management Systems not necessarily directly connected with client care. This new technology could also result in a "speeding up" of work processes and patient throughput thus increasing the stress.

Shiftwork

Shift work has been identified by Cooper et at (1988) as a cause of work stress as it can interfere with body function, sleep patterns and family life. Shift work has always been a part of nursing life. Night duty and working until 9 pm or 10 pm in the evening on day duty, is expected, as are working weekends and bank holidays when most partners are not working. Often there is an unwritten agreement between partners that this is acceptable to improve income. Working night duty, a nurse could earn a reasonable amount of money in a relatively short week, usually over fewer nights and this was often chosen for this reason by married nurses. Similarly part-time staff often worked between 5 pm and 9 pm and weekends, when their partner was at home to help with child care. There is also a historical acceptance that nursing is a "vocational calling" and therefore nurses are dedicated and self-sacrificing and will work all hours. This belief could equally apply to the nurses in management who are also tied to the shift system.

However, until recently a nurse, once qualified could choose to work day duty or night duty, full or part-time. Now with limited resources in health care, there is a need to use resources effectively, therefore shift patterns are constantly under review and nurses are no longer offered the choice of "set hours", day duty or night duty to enable family and job commitments to be managed. With the ward sister responsible for client care over the 24 hour period, internal rotation to night duty and day duty is becoming the norm, ending the separation between night staff and day staff, with the aim of improving continuity of care. This could lead to economic problems if nurses cannot meet the expectation of internal rotation and have to leave employment. This seems a contradiction when the emphasis within the National Health Service is to encourage flexibility of working patterns, to encourage people with family responsibilities, to return to the profession. The Government's initiative "Opportunity 2000" aims to encourage women to

be employed in senior positions. This will be difficult if child/family support is not available. Hingley, Cooper and Harris (1986), found that some nurses in management felt their domestic commitments inhibited their career prospects. There is evidence to suggest that female nurses, on average, take much longer than their male counterparts to reach managerial positions (Equal Opportunities Commission 1991). Nelson and Hitt (1993), state that although women face the same stressors as men in the work setting, they also face several unique stressors. These include discrimination, stereotyping, social isolation and work/home conflicts. It is the management of home and work commitments that can be an increased stressor for nurses within the shift system.

Long Hours

With the review of shift patterns there seems to be a move to longer working days as a means to improve continuity of care, but with a shorter working week. Cooper et al (1988), suggest that long working days and weeks increase the risk of death from coronary artery disease in those under 45 years of age, who work in excess of 48 hours per week. There is currently a debate between the British Government and European Court regarding the length of the working week not exceeding 48 hours. Nurses currently work 37.5 hours per week but often work overtime for which they may or may not be paid, or receive time off in lieu. In this instance it is the longer working day rather than the longer working week that affects nursing. Cooper (1991) identified that over a period of approximately 4 years he accrued 651 hours overtime, which averages to 4 hours per week, excluding holiday. In itself this is perhaps not significant, but when continuous with no respite in the form of time back, then it can become unacceptable.

He stated it was "not the done thing to take time back nor was it practical" (Cooper 1991 : 28) This expectation that nurses should not take

time back is not specified in any documentation. It is difficult to ascertain from where this belief arises. Cooper (1991) goes on to say that an individual who refuses to work overtime is left feeling guilty and that often interferes with their ability to relax on their day off. One could give the counter argument that if the individual does work overtime their guilt may be related then to the family.

The majority of staff employed as nurses in the NHS are women (Department of Health 1992). With the changing role of women in society more nurses are now married with children and work full-time. This can lead to difficulties trying to balance the needs of both the family and home with their working role. The expectation of society is that nursing is a vocation, therefore nurses often experience hostility if they behave realistically or demand better conditions for themselves. (Health Education Authority 1988). The experience of Cooper (1991), would perhaps support this finding. With regards to nurses in middle management, anecdotal evidence would suggest that when one reaches this position, there is an expectation that the employee will work the hours necessary without any maximum, although he/she may have a contract of 37.5 hours.

Work Overload and Underload

Whilst Cooper et al (1988) mention both work overload and underload, no literature was obtained relating to work underload in nursing, hence work overload only is discussed.

Understaffing leading to work overload is one of the most frequently voiced complaints of nurses and historically this has been accepted. However this assertion that nurses are overworked due to understaffing has been challenged and now must be substantiated. Managers must now demonstrate

by systematic /evidence based means the nursing workload through patient dependency and skill mix reviews for each individual ward. In the past nurses were often involved in tasks not appropriate to their role e.g. domestic work. (Hingley Cooper and Harris 1986). Now patient management systems assess the actual nursing time each individual patient requires throughout the day and what grade of nurse should give that care. These systems do not consider non-nursing duties. To fulfill purchaser/provider contracts, patient turnover is increasing in acute areas, with a corresponding rise in client dependency (see fig.1) Patients are in hospital for a shorter period of time but are more dependent in that time. The patients are discharged into the community sooner, thus increasing the workload for the community staff, who now also have a greater number of patients requiring a higher level of care, because of their increased dependency. Some of this quick turnover of patients could be attributed to the increased technology as suggested earlier, resulting in more day case surgery and shorter hospital stays.

THE THROUGHPUT FACTS

- From 1979 to 1990 in-patient cases treated by the NHS increased from 5.4 million to 7.4 million
- In the same period the average length of stay for acute medical patients fell from 11 day to 8 days
- Maternity stays dropped from 6 to 4 days (1979-90)
- Geriatric stays dropped from 77 days to 41 days (1979-90)
- From 1979 to 1990 there has also been a 20% drop in the average number of beds available daily, from 362 to 270
- Between 1988/9 and 1989/90 alone, the NHS took on 2% more in-patients, even though the number of beds fell by 5% in those months
- During the same period, the number of people treated in each bed increased by 7% and there was a 14% rise in surgery cases

Fig. 1 (Mason P 1991)

According to Mason (1991) citing Wise, a Labour member of the Commons Health Select Committee, there seems to be a reluctance on behalf of the Government to acknowledge that there is a problem. Increased workloads are seen as part of the challenge of managing a modern hospital. However if staff are worked too intensively, then no amount of good management can counteract the effects of this.

Mason goes on to cite interviews from nursing personnel, quoting the problems of increased throughput of patients. The quick turn round of patients does not allow nurses to get to know them. Increased pressure can cause animosity towards the hospital hierarchy and a fear of making mistakes. One sister quoted in the article stated the average stay for a patient in her investigation unit was 90 minutes. This makes the nurses feel they are working with a conveyor belt system and not dealing with human beings. The speed at which they work makes them fearful of making mistakes. Similarly they do not feel they have time to talk to the patients to allay their fears and give information, which is an important part of the nurses role. (Hayward 1975, Lane-Franklin 1974) This throughput, coupled with long working days, could lead to exhaustion; physical, psychological or both.

This increased work load not only affects the acute areas but also continuing care. In continuing care areas whilst dependency levels can be high, turnover is less and it seems that an assumption is made that these clients require less highly trained staff and fewer carers generally. This increases the workload for staff in that area. Understaffing and increased workload may also lead to an increase in nurse injuries. In a survey conducted by Mackay (1988) she found 38% of staff had sustained injuries at work. However it is not clear from the article how far this is linked to increased workload, other than a reference that nurses were rushing to ensure "jobs

done" . In the article Mackay states that 86% of all nurses interviewed in the survey felt that nursing was a stressful job and the main cause is understaffing.

Travel, Risk and Danger

Stress associated with travel may depend on the locality and the nurse, the type of work they do and the distances they may need to travel to work. In the London areas staff shortages have resulted due to the expense of travelling into the capital and the cost of living there. Fear of travelling alone at night experienced by most women nowadays has also exacerbated the problem. Shift work often means travelling at times when there may be few people around. Whilst on one hand this may increase stress as one may feel more vulnerable, it may also reduce stress compared to rush hour travelling with its increased traffic and people. Community nurses travelling alone to see clients/patients often with no means of ensuring personal safety, are feeling more vulnerable nowadays. This has been cited as a cause of stress by health visitors. (Fletcher et al 1991). Nurses on night duty may fear leaving the ward for meals to walk through isolated corridors, or returning to residence through badly lit hospital grounds.

Risk and danger associated with the job itself again is a difficult area to generalise about. Nurses working in Accident and Emergency areas can experience all sorts of violent situations in the department. They may also have to attend major accident situations when they are in danger travelling to the site of the accident and at risk once at the site when helping others. Tattam (1990) cited an incident in West Berkshire where a nurse, in the grounds of the hospital had been raped at knife point. Tattam goes on to cite many incidents of theft from nurses' residences due to poor security. In one incident a man burst into a nurse's room whilst she slept. Although it would appear intruder problems and theft are on the increase there is little hard evidence. The Home Office does not keep separate figures concerning violent

crimes against women although these crimes did increase in the 1980's (Tattam 1990).

2. Role In The Organisation

Cooper et al (1988) suggests that stress can occur when an individual's role within the organisation is not clearly defined or when role conflict exists. The individual is torn by conflicting demands. The responsibilities associated with a role also appear to create stress, with most stress being associated with responsibility for people along with budgets and equipment.

Within nursing, individuals usually knew their role, where they fitted into the organisation and the responsibilities of that role. There was a clear hierarchy of responsibility from the nurse managers, ward sisters down to the qualified and unqualified nurses. However this clarity of role is no longer as clear with the changing patterns of nurse education and health care management. For example student nurses were once very much part of the ward team and were relied upon, spending most of their training in the clinical areas. Now with the changes in their education in the form of Project 2000 (UKCC 1986) they spend less time in the clinical area and most of that time is supernumerary status i.e. they are extra to the ward team and the team can function without them. They now have some degree of uncertainty as to where they fit into the team. Similarly staff are not sure what to expect from them. Student nurses are less involved in patient care now than previously. Research is ongoing regarding the effects of the changes brought about by Project 2000 on both students and qualified staff. (Jowett, Walton and Payne 1994)

The United Kingdom Central Council's recent Code of Conduct (UKCC 1992) places accountability with the Registered Nurse. Student nurses must

work under the supervision of a registered nurse. Unfortunately they are sometimes excluded from particular aspects of care, as it is quicker for the nurse to do something for the patient without having to teach the student at the same time. This could aggravate the uncertainty as to where students fit into the team and the expectations of them.

Nurses are now encouraged to take on an increased range of technical tasks previously carried out by doctors. The notion behind this is to improve the continuity and quality of care received by patients, whilst reducing junior doctors hours. This is achieved by reducing the length of time a patient may have to wait for a doctor when a nurse is capable of fulfilling that role and is more freely available. The United Kingdom Central Council (1992), have endorsed this development with the issue of the document "The Scope of Professional Practice". In this nurses are guided to ensure the procedures they take on will benefit the care of the patient or client. Attention in the document is drawn to the nurse's accountability for his/her actions if the nurse exceeds his/her sphere of knowledge or practice resulting in patient harm. This document was issued at the time that there was great debate about the reduction in junior doctors hours. Many nurses were initially concerned that they would be expected to take on extra duties without preparation. This they feared could lead to personal litigation without the protection of the Health Authority or Trust.

Responsibility for people has always been part of the nurse's role. The nurse is expected to be totally committed to his/her patients who may be anxious, in pain or dying. Nurses need to support both patients and relatives, though until very recently received little training themselves to handle these events. The emotional demands of that aspect of the nurses' work was not recognised. Fletcher et al (1991), found that particular cases amongst health visitors caused stress, such as bereavement and non-accidental injury. If these

factors are linked with understaffing and work overload, the assumption can be made that stress will increase. Copp (1988) suggests that nursing is a stressful occupation by virtue of the demanding stimuli that constantly impinge on nurses. One action to reduce this stress would be to avoid such stimuli as bereavement or child abuse completely, but, this action would result in a reduction in the quality of care and is therefore not an appropriate course of action for nurses.

The nurse is often pivotal to patient care, the interface between the patient and necessary resources, be they human or material. Whilst this management of resources was seen as an integral part of the Ward Sister/Team Leader role, he/she did not have to concern themselves with the cost of these resources. Before the Griffiths Report in 1983, (Department of Health 1983) that was totally the responsibility of the Hospital Administrator. Now budgets are often devolved to the ward manager who is expected to ensure no overspend. That has been reinforced with the NHS Reforms. In earlier nurse training programmes, nurses were not prepared for this role and many were expected to "learn on the job". Even now, this preparation is only addressed after qualification, often after promotion to ward manager or in some instances not at all. This, once the less stressful part of the role is now creating stress for many, as the resources are now more tightly controlled. In the past, if a new bed or piece of equipment was needed, it was ordered. Now that need must be justified and money usually has to be found from existing resources within the ward or division.

Even as the role for nurses within the NHS is changing, so is the role of the nurse in middle management. This nurse manager initially managed the nursing resource, now they may be expected to manage the total resource of the division which may include both human and material elements. The decisions about the division may be made with or without their involvement.

This aspect will be further explored in the next chapter concerning organisational structure in the light of the changes following the NHS reforms.

3. *Relationships At Work*

The role of the nurse in middle management in the organisation, even if clearly defined, can be a stressful role. Not only may they encounter the situations previously described, but they are expected to support staff in those situations. Davidhizar and Farabaugh (1988), suggest the responsibilities of a nurse manager are complex, involving resolution of interpersonal conflicts amongst patients, relatives and staff, motivation of employees and management of resources. Whilst their study concerned primarily operating department managers, there are likely to be similarities with other middle managers in nursing.

Cooper et al (1988) states that other people and/or encounters with them can be major sources of stress or support, citing relationships with superiors, peers and subordinates. It has already been suggested that there could be animosity towards the hospital hierarchy due to work overload which does not make for easy relationships.

Rigid hierarchical structures which lead to poor communication, little involvement in decision making and planning for those lower down the system are other factors that appear to cause stress. Fletcher et al (1991) cited nurse managers themselves as a source of stress due to their poor communication and interpersonal skills, resulting in a relationship that offered little support and feedback for health visitors. Support and feedback on performance was seen as important to the respondents of this study. According to Rice (1992) we all need support networks, be they family, friends or work colleagues.

Development of our self-esteem depends upon feedback from others. Lack of feedback from senior staff leaves an employee wondering how they are doing, "am I getting it right?" . This uncertainty about one's performance can contribute to feelings of stress at work, especially in the hierarchical structure where the opinion of those lower down the system seems unimportant.

Relationships with peers can be seen as supportive, a means to share experiences and fears thus defusing them. The isolation therefore experienced by those nurses who in the main work alone, could lead to stress. For example, Wilkin (1998) identified feelings of vulnerability and isolation working as a community psychiatric nurse. However relationships with peers is not always supportive. Nurses appear to vent their frustration with the system by criticising other nurses, readily identifying faults but ignoring strengths (Gillian 1994). Whilst professional shortcomings have to be faced to ensure practice is improved, negative criticism of each other is common in the profession. Why is this so? Could it be that with the current re-organisation and change there is a fear of job-insecurity possibly leading to professional rivalry. This possible supportive network therefore may now be seen as a competitive network, thus the peer support may no longer be there. An individual will not generally share anxieties or weaknesses with a competitor.

As relationships with superiors and colleagues can lead to stress, so can relationships with subordinates. Within the nursing system, managers are often seen as distant and autocratic which is emphasised by the hierarchical structure. This in turn can lead to a manager feeling a sense of isolation and "not belonging", aggravated by lack of peer support arising from professional rivalry (Hingley 1984). It is possible that this group of nurses within the profession may experience higher levels of stress but are less likely to admit to this because of the current insecure situation. No-one wants to be seen as not being able to cope. Hingley (1984) suggested that this isolation due to role

resulted from managers not feeling involved in the decision making and questioned whether this was due to lack of preparation. Following the reforms there is more devolvement of the decision making process but are managers prepared for this?

There appears to be some overlap between an individuals role in the organisation and relationships associated with that role. A nurse manager may have difficulty with relationships purely because she/he is in that role and perceived by staff to be the source of their stress. If for example the nurse manager is responsible for the implementation of a work review, (because that is part of her/his role), which in turn results in an apparent increase in work for staff, it is quite possible their relationship with that manager will change. She/he will be seen as responsible for causing increased stress for them.

4. Career Development

Cooper et al (1988) suggest many career development issues can act as potential stress factors throughout one's career e.g. job insecurity, fear of redundancy, staff appraisals and evaluations.

Job insecurity at one time within nursing was not seen as a problem. The expectation was that nursing was a job for life and the nurse chose when to leave. That pattern is changing. Fletcher et al (1991) describes the feelings of health visitors and their fears that if their role cannot be quantified it may disappear. "Good health visiting" which reduces health problems is difficult to measure. Health visitors could therefore be seen as an expensive resource. Qualified nurses are expected to continue to enhance their professional knowledge. The United Kingdom Central Council issued a document to the profession stating that all nurses wishing to remain on the professional register must demonstrate evidence of updating prior to the three yearly re-

registration (UKCC 1994). Any nurse who cannot demonstrate updating will not be able to re-register and thus not be able to practice. This is another fear for nurses relating to job insecurity especially as opportunities for professional development are not standard throughout the country.

Within health care, skill mix reviews are becoming more common as the need for expensive qualified staff is assessed. Indeed within the former Northern Region it was decided that the nursing posts at Region were "no longer appropriate and no longer required", and thus the post of Nurse Advisor and others were redundant (O'Neill M. 1993). If senior nursing roles are "no longer required" then what career development is there for nurses who wish to progress in the profession? Lack of career progression has been cited as a major cause of nurse stress (Hingley and Harris 1986 and Bamber 1991). Strong and Robinson (1990) not only refer to the critical approach in nursing as mentioned earlier by Gillian (1994), but also to the career instability or insecurity of nurse managers since the NHS reforms. Contrary to medical colleagues who "close ranks" when threatened, nurses often appear to gain some perverse satisfaction from seeing colleagues insecure in their role or criticised on their performance. (Strong and Robinson 1990 : 32-41)

Nelson and Hitt (1993), propose that a potential source of stress for women is career progression, particularly in a male dominated workplace. Although within the NHS the largest number of employees are nurses and those nurses are mainly women, proportionally the senior positions in the Health Service are held by men (Tate 1996). The former Northern Regional Health Authority, in response to the Government's Opportunity 2000 initiative attempted to address this issue. The Region attempted to actively recruit to their Management Development programme a specific number of women. They were unable to achieve their target. The reasons for this are not known.

However one can speculate. Whilst the Regional Health Authority

attempted to assist the career progression of women in its workforce, what support, encouragement and information did women in the various Trusts receive? The communication of this initiative was poor and very few middle and senior managers knew of it. Communication of the project was to Chief Executives/Chief Nurses through a seminar. It was then left to them to disseminate the information to their staff. Surely an initiative of this importance warranted more exposure to ensure those who may be interested and had potential were targeted?

So far, the causes of stress at work as proposed by Cooper et al (1988) and concerning factors intrinsic to the job, role in the organisation, relationships at work and career development do seem to have some currency when applied to nursing. The literature reviewed can be related to these areas. However most of the literature does not specifically relate to nurses in management, being more generalised in its application. For that reason this question will be re-addressed with the respondents involved in the field work and a comparison made following that, as to the causes of stress at work for them.

One of the questions posed at the beginning of the thesis concerns the organisational structure and how far stress is aggravated by that structure particularly following the NHS reforms. As a means to explore this question, the suggestion by Cooper et al (1988) that the organisational structure and climate can predispose to stress will be explored in the context of the NHS past and present in the next chapter. Did the former organisational structure of the NHS cause stress? If so, is that stress aggravated or reduced by the NHS reforms?

CHAPTER 3

ORGANISATIONAL STRUCTURE AS A POTENTIAL CAUSE OF STRESS AT WORK

The second question posed at the beginning of the study is; How far is stress aggravated by the organisational structure of the NHS and the recent reforms.

In this chapter, it is proposed to explore the current organisational structure of the NHS and compare it with that of the past to investigate how far the structure may aggravate feelings of stress for employees. This stress may be related to the change in one's role in the "new" organisation, resulting in a change in traditional career developments. How are these changes influencing the stress factors mentioned in the previous chapters? Are these changes reducing or increasing the feelings of stress for employees ? From the literature reviewed so far there seems to be some suggestion that to admit to stress in the NHS is a weakness (Wilkin 1988, Cooper 1991). What part does the organisational culture play in influencing this belief?

Schein (1988) defines an organisation as :

"The planned co-ordination of the activities of a number of people for the achievement of some common, explicit purpose or goal, through division of labour and function and through a hierarchy of authority and responsibility" (Schein 1988 : p15)

The common, explicit goal of the NHS as perceived by society is the promotion of health and the diagnosis, treatment and care of people who are

ill and those working within that organisation supposedly do so to fulfill those purposes. However the division of this labour has changed within the NHS since its inception in 1948. Recently the NHS has undergone vast changes following the governments' White Paper "Working for patients : The Health Service : Caring for the 1990's". (Department of Health 1989) The purpose of this chapter is to explore how these changes may or may not contribute to the feelings of stress in the workforce. The speed and extent of change in the last few years has been rapid and far reaching compared with previous NHS organisational changes.

Organisational Change in the NHS

The NHS was established in 1948. It had a hierarchical structure with many tiers above the level of ward sister. Most of those senior positions in the hierarchy were held by men, and those men were generally doctors. The administration of the NHS was based on expertise, clear divisions of labour and management with established rules and regulations. The policies and procedures at the time were made by the people with the power. These were generally doctors and politicians and there was limited, if any involvement of patients and non-medical staff involved in care delivery. Despite reforms in the late 1960s resulting in the replacement of the matron by Directors of Nursing Services, the hierarchy, particularly in nursing remained. Following reorganisation in 1974, the Directors of Nursing Services became subordinate to District Nursing Officers. These reforms of 1974 which despite introducing elements of business by improving administration maintained the traditional bureaucratic framework. One could argue however that the framework had now even more tiers of management above the level of care delivery. Funding was still controlled centrally and managed by a team of officers both at district (local) and regional levels. This was not the case within most other large

organisations at the time who had an executive officer in overall control. In the case of NHS, there was consensus management.

However, in 1985, following the Griffiths Inquiry into NHS management there was a more radical re-organisation. (Department of Health 1983) This reorganisation moved the NHS from consensus management (an important element of the 1974 re organisation) provided through District Health Authorities, to General Management. In this scenario, under general management, an individual accepts direct and personal responsibility for the development and planning of services and the monitoring of achievement. Griffiths maintained that the process of consensus management used previously by the District Management Teams was too slow. Thus, the structure following this change became much "flatter" and more responsibility was devolved directly from the General Manager to individual units and divisions.

The recent re-organisation stems from the Government's White Paper, Working for Patients (Department of Health 1989), creating a new tier, the Trust Boards. It separates the purchasers of health care from the providers, mainly NHS Trusts. This process has divided the providers in the NHS into units, each individually managed by a team of officers and by a Trust Board. In most areas Hospital and Community Services are separately managed Trusts, each contracting individually with the purchasers. The aim of this re-organisation was to improve the cost effectiveness of the services, through competitive pressures. The Health Authority purchases, through annual contracts, services from the provider units. The provider units offer a service at a particular cost to the Health Authority but if the Health Authority is not satisfied then it may take its "business" elsewhere. The Health Authority is not confined to its local provider Trusts, producing the "internal market" concept.

A second area in which reform is occurring is primary health care following publication of the governments White Paper : "Promoting Better Health" (Department of Health 1987). This aims to raise standards of health care, emphasizes health promotion and disease prevention and offers wider choice and information to patients. This places more work, especially preventive work, with the general practitioner some who have become fund holders following the 1991 reforms. Overall the emphasis has shifted in the recent years towards a primary care led NHS.

A third recent document has had important implications for the NHS. The aim of The White Paper, "Caring for People" (Department of Health 1989) was to overcome the slow and uneven development of "Community Care" Services across the country. This placed lead responsibility for community care with the local authorities. The moneys given and transferred to local authorities would be used to develop more effective community based care. Assessment of individual health and social care needs is crucial in the allocation of resources. The significance of this is the potential loss of revenue to the Trusts to Social Services.

With changing patterns of care delivery, there has been a retraction in the number of acute beds due to an increase in day case surgery and reduced post operative stay, with patients discharged to the primary care staff sooner. Large Mental Health and Learning Disabilities institutions have in some instances closed completely, clients being cared for in small units in the community or at home with carers and support again from the primary care team, and other community staff e.g. social workers and voluntary organisations. The main debate around these changes, concerns the allocation of resources. It is stated by those working in the community that the resources have not followed the patients resulting in an increased workload without appropriate resources resulting in vulnerable clients not receiving the care and

support required. (Dept. of Health 1994) Following full implementation of the Community Care Act in April 1993 (Dept. of Health 1990) the debate around resources has continued centered around the division of responsibility between health and social services.

How then have these changes affected nursing and nurses in middle management? Prior to Griffiths, nurse managers had clearly defined roles and responsibilities. Their role was to manage the nursing resource and monitor patient care based on their experience and ability. Issues of finance and other resources were managed and controlled by others and whilst there was a nurse on the District Management Team and involved in such issues, middle managers still managed only nurses. Their role was quite structured and clearly related to nursing. Nursing is the largest cost to NHS resources, thus more accountability for the use of that expensive resource was demanded by the General Manager. The District Nursing Officer had to account to the General Manager for the costs of nursing provision. Similarly Divisional Nursing Officers and Nursing Officers were also beginning to be asked to account for the cost of the nursing service to the District Nursing Officer. This accountability for costs extended even to those in nurse education. At that time in most District Health Authorities, student nurses provided a third of the workforce. Managers of nurse education were asked to account for peaks and troughs in the allocation of students to certain areas, which resulted in a cost to the Authority for replacements or inefficiency due to overstaffing. From personal experience this seemed to be a national situation.

Following the changes in 1991, separating the purchaser from the provider of health care, each Trust, through its team of officers is responsible for that service and its resources. The development and production of contracts between purchasers and providers has necessitated a change in thinking. Trusts must be competitive in as much as they must be proactive to meet the demands of a changing service. There are limited resources which

have to be managed. Each Trust is responsible for the total resource. They must offer an effective service at a price the purchaser can afford. If not, the purchaser will go elsewhere. As the providers change to meet the needs of the purchasers so must the managers change within that service. No longer are nurse managers solely concerned with nurses. These managers have become more general managers and their interface with the organisation is no longer so specific. Their role is an evolving one concerning competitiveness, change and financial constraints. Pressure to provide more and better information has been increased by the contracting process, thus increasing the pressure for nurses in management roles. How prepared for this evolving role are nurses? Do these managers need to be nurses?

In some provider units, ward managers (formerly sisters or charge nurses) report to a manager who is not a nurse. In other areas ward managers report to a manager who is a nurse but whose role has expanded dramatically since their initial appointment. It is this constant evolution that could create feelings of stress due to role ambiguity. As the service changes to meet health care needs, clear divisions of labour are no longer possible. It could well be that the changes of one's role in the "new" organisation are indeed a source of stress rather than the changes themselves. There are no longer clear role boundaries and job descriptions. The rapid change of health care resulting in a change of health care delivery following the reforms seems to be influencing the stress factors previously mentioned thus increasing rather than decreasing the stress.

According to Ross and Altmaier (1994) the more an individual employee is involved in direction and decision making in their work, the less stress is likely to result. In flatter organisations more job satisfaction, less job stress and better work performance has been reported (Ross and Altmaier 1994 : 48-49). This should suggest that now the NHS has become "flatter" with more decisions devolved to a lower level, the stress should reduce. This

does not seem to be the case. In a recent random sample of nurses it has been suggested that "stress levels are growing" and that there is an increase in the number of nurses committing suicide (Day and Payne 1995). Whilst reference was made in the article to the debate concerning the validity of the findings of the survey, concerning whether or not these were all practicing nurses, factors identified as contributing to these increased stress levels were reduced job satisfaction, the emergence of short-term contracts leading to job insecurity and possible financial hardship. These are similar factors to those already discussed in the previous chapter. Job insecurity in the past, was not a concern for nurses. Now however with the contracting process and the use of performance indicators this is no longer the case. If a provider unit loses a contract or re-designs its service to meet purchaser and client need, then jobs may be lost. No longer is nursing a job for life. Nurses who could once choose when and where they worked no longer have that choice. It is now a case of trying to stay in employment. The stress associated with job insecurity is aggravated by the fact that in parts of the country such as the North East of England, the woman is often the "bread-winner" thus increasing the need to stay in employment.

So far it seems that the changing organisational structure could have some part to play in causing stress. However it has also been suggested earlier that to admit to stress in the NHS is a weakness. From where does this idea arise? Handy (1985) suggests each organisation has a "culture" and this culture influences the individual to adapt its values and customs through socialisation. Could it be therefore the organisational culture which prevents staff acknowledging their stress?

ORGANISATIONAL CULTURE

Glen (1975), describes informal social factors such as attitudes, value systems and forms of social behaviour which are either encouraged or sanctioned by the organisation in the way conflict is handled as part of the culture. According to Handy (1985), each organisation, and each part of an organisation has a culture. He describes four broad types of culture, however more than one culture can co-exist within an organisation.

i) Power Culture

This is traditionally seen in smaller family firms. There is generally one central dominant figure who responds quickly to problems and decisions. There tends to be no committee structure or consensus decisions. This culture tends to support an autocratic style of management.

ii) Person Culture

Within this culture Handy (1985), suggests the person is of prime importance. The only reason these individuals come together is to support the activity. Within this type of culture there is difficulty in working together and no-one accepts responsibility. It would be difficult for an organisation to function with this culture. There is no collective purpose or sharing of common goals as proposed by Schein (1988) which according to him are the reasons why the organisation exists.

iii) Role Culture

This is often stereotyped as bureaucracy. There is a hierarchy, a senior team with functions delegated down clear lines of communication and demarcation of roles can be demonstrated. The role is more important

than the person in the role. This culture recognises position power rather than person power. Initiatives from below are often stifled. Control is exerted through positions in the organisation. The assumption made is that what works now will work forever, clear lines of responsibility, job description and role clarity being paramount. Control in this culture is exerted from above with little involvement of subordinates. The advantage of this culture is the feeling of clarity and security. This culture seems to describe the "old" NHS. So, whilst on one hand stress can result from lack of control or influence, this lack of control and influence can also give a feeling of safety. Individuals know where they are in the system and what is expected of them.

iv) Task Culture

This is a constantly changing culture which is sensitive to changing needs. There is no one person responsible overall, rather groups of people working on projects. This culture encourages ideas from all, irrespective of an individual's perceived role in the hierarchy.

In this time of changing health care, this culture appears to have its place. If a Trust cannot change to meet its purchaser's requirements then it will fail. However staff need to be aware of and support the changing values and beliefs of the organisation to enable them to work within it. Whilst divisions within the Trust work independently they must recognise that the overall activity of all divisions ensures the viability of the Trust. Is this the culture that is now evolving following the NHS reforms? In this culture there is no clear demarcation of roles, with less role clarity but more involvement in the function of the organisation. How do these features affect those working in the NHS?

Handy goes on to suggest that individuals are attracted to a particular organisational culture. e.g.

a) Individuals with low tolerance for ambiguity will prefer the tighter prescription of role culture

b) High needs for security will be met in the role culture

c) A need to establish one's identity at work will be appropriate in power or task culture

d) The impact of individuals skills and talents will be more marked in power and task cultures than in role

e) Low calibre people resources - in the sense of intelligence or interpersonal skills, would more likely push an organisation towards a role culture with clear demarcation of roles through job descriptions and seniority.

(from Handy 1985 : 204)

Any classification of course has its limitation. These classifications described by Handy (1985) are "ideal types". Most organisations will show features of more than one but it is the balance of these that gives each organisation its own "culture". It is perhaps the changing balance within the NHS that is creating the problem for staff. Initially within a bureaucratic system of management, a role culture was most likely dominant, now however there is perhaps a move towards a task culture, resulting in feelings of insecurity and role ambiguity, thus increasing feelings of stress.

It has been alluded to in the previous chapter (infra page 30) that to admit to stress, (in this specific situation caused by work overload), is not expected. Why is this so? Within a role culture an assumption could be made that if one accepts a role within the organisation, then there is an expectation one is capable of that position. A person who believes they are incapable in that role or that the demands of the job appear to exceed their abilities in the form of work overload, may then begin to feel stress. They may be reluctant to admit

to those feelings, as to admit to stress could imply they are not coping with the job expected of them.

As the NHS changes its organisational approach to become responsive to the health care needs of society through the purchaser, then so must the culture change. In the past nurses through the hierarchical structure knew their role within the organisation, there were rules and rituals to follow. Decisions of importance related to general resources and finance were not their concern. Now nurses are expected to at least be involved in the process and as health care changes nurses must also change to meet the need. Indeed the expectation of Project 2000 education, is that nurses of the future will be adaptable to meet the changing needs of health care (UKCC 1986). No longer can nurses blame "those above" for the problems. They are expected to contribute to their solutions. It may be that the cultural change is not occurring as quickly as the organisational change and it may be this that is increasing the stress felt by nurses. Mason (1991) suggests that nurses working within this new business orientation feel that the patient is no longer the focus of care and that cost and cost reduction is of prime importance, to "process" as many patients in as short a time as possible . This has led to opposition by many nurses to the reforms and subsequent low morale.

According to Ross and Altmaier (1994) stress may also result from competition. Following the NHS reforms this aspect of competition has arisen due to the purchaser/provider split. For a Trust to remain viable they must compete with other Trusts for Health Authority contracts. According to Jick (1985), the competition generated within an organisation results in feelings of job insecurity, work overload due to unrealistic deadlines, under utilisation of employee skills, promotional obstacles and intra-intergroup competition. Nurses working within different divisions of a Trust may no longer have the support of their peers. Their peers may now be working for competitors.

To some extent the feelings of stress generated by the events and culture, will depend upon the perception of control an individual may feel they have over the system or situation. Those nurses who perceive that events are related to their own efforts may see the change in the system as an opportunity, one in which they can exert some control or direction. Conversely those nurses who perceive events as a result of fate or powerful others (e.g. management or politicians) may feel out of control and exhibit feelings of helplessness and stress. Phares (1991) refers to this as the Internal External notions of control, considered within "locus of control" theories.

An individual who believes that their behaviour will have some influence over the external events affecting them, is termed as having a belief in internal locus of control. They believe they can have an influence on a situation. Conversely those who see events are controlled by others have a belief in external locus of control, and believe they have no influences over these external situations. This suggests some personality issue. Perhaps as Birch suggested in 1975, personality should be assessed prior to recruitment to the profession.

It is possible that stress may arise or increase when an individual who has a belief in external control and has been working in a role culture, with its hierarchical structure suddenly finds that changing. A role culture would appear to suit those with a belief in external control because of the rules and regulations laid down by others. The insecurity employees may feel as that culture changes could generate feelings of stress, after all they have no control over these changes, but are expected to be involved in their implementation. Conversely those who have a belief in internal control will see these changes as an opportunity for them and may not find the change so stressful.

In this chapter the organisational structure and nature of the NHS now has been compared with that of the past. It appears that following the implementation of the Griffiths report and the NHS reforms, the NHS structure has changed. There is now one officer in overall charge of the Trust with devolvement of decisions now nearer to direct client care, it is much less hierarchical. The nature of services has also changed with a move from secondary to primary care, faster turnover and increased technology.

The literature would suggest that because nurses and particularly nurses in a middle management role are more involved in the decision making following the NHS reforms, their stress should be reduced, this may not necessarily be the case. In this and the previous chapter the role of the nurse in middle management was explored and there would seem to be a suggestion that stress may actually have increased following the NHS reforms. Their role is changing and evolving continually and they may have had little preparation for that. Add to that, the changes related to health care delivery and structure occurring within the organisation itself and this stress is possibly increased.

Initially a role culture appeared to predominate in the NHS. That meant those working in the organisation were aware of what was expected of them and that gave them some security. Now staff are not so sure of what is expected and therefore that security is not as evident resulting in stress for those concerned. Fear of job security associated with possible loss of contracts or change in service also appears to compound that stress. The organisation is undergoing change, not only in its structure but also in its culture. The changing NHS would seem to be better fitted to supporting a task rather than a role culture but is that what is happening? There may be some dissonance between how the organisation is attempting to function through its structure and how its culture with its associated values, beliefs and norms of behaviours, assist or inhibit that function.

It is difficult therefore to identify what factors are associated with stress for this particular group of nurses. All the factors associated with stress at work proposed by Cooper et al (1988) appear to be related to nursing. What is not so clear, is whether or not all these factors are associated with nurses in a middle management role, some appear more pertinent than others. The organisational structure following the NHS reforms does appear to have the potential to decrease employee stress but because of its evolution and change may in fact be increasing that stress.

Finally, to admit to stress within the NHS is seen as a weakness, suggested by Wilkin (1988) and Cooper (1991) the reasons for this are not clearly evident. The culture may indeed influence that belief. Within a role culture perhaps to admit to stress associated with work was perhaps to admit to not coping with the role. Those who have worked within that culture therefore may find it even more difficult to admit to stress as the organisation changes. Their roles are no longer as clearly defined and expectations not as explicit. It is difficult to distinguish whether stress for those nurses in middle management is caused by their changing role in the "new" NHS or the incompatibility between the culture and organisational structure or both. This needs to be explored further through the field work.

So far, from the literature the first two questions posed at the beginning of this thesis related to the causes of stress at work and the effect of the organsational structure on that stress, following the NHS reforms have been explored. It appears that working in the NHS can result in stress by virtue of being part of the organisation and not only due to being involved in direct patient care as previous works have shown. This stress can be exacerbated by the organisational structure and culture. In Chapter 1 an examination of the effects of stress on an individual was made recognising that the degree of stress

was dependent upon individual perceptions. The literature acknowledged that whilst a certain amount of stress could improve performance, too much stress could indeed impede performance. If this is the case, what are the implications of this for the organisation whose staff may be experiencing stress in the work setting.

IMPACT OF INDIVIDUAL STRESS FOR THE ORGANISATION

A worker who is finding it difficult to cope at work, feels his/her talents and abilities are not being recognised, or has problems with relationships at work is not likely to give their best. However, add to this domestic worries, such as difficulties with children, money or bereavement and the problem could be enormous. The employee cannot be expected to "switch off" from their domestic problems when they come into the work environment, and these problems may at times impinge on their work performance. Similarly it needs to be recognised that an employee who is experiencing difficulties at work may take these difficulties home resulting in domestic problems. Stress, irrespective of cause, resulting in interference with performance not only affects the individual but potentially affects the organisation, through increased accidents, increased absenteeism or a general under performance. Recent estimates have suggested that individual hospitals may incur costs in excess of £1 million due to employee absenteeism (Seccombe and Buchan 1993). It is therefore in the interests of the NHS to respond in some way to assist employees cope with stress. If the NHS or any organisation chooses to ignore stress in its workforce, the potential outcome of that stress will ultimately result in a reduction of performance by the organisation.

It is likely that employees experiencing stress may find themselves at times overwhelmed by "tension and pressure" (Megranahan 1989). The effects of this stress have been seen to interfere with employees ability to perform in the work setting. These effects of stress will not only affect the way the employee functions, but may result in the loss of that employee to the organisation. Those individuals who move elsewhere are likely to be the most able individuals, with skills and talents that are desirable and necessary to the organisation. The organisation that does not acknowledge stress, can suffer therefore in two ways. Not only may its performance be reduced, but it potentially runs the risk of loosing its most able and talented employees.

In this time of rapid change in health care the NHS needs to respond quickly to changing needs. An inefficient work force due to stress will interfere with the organisation's performance and ability to react to health care needs. It is for this reason that an organisation needs to consider strategies that will compliment an individuals own coping ability and support them should their own coping strategies become overwhelmed. The effects of implementation of such strategies need to be evaluated as a means to inform the organisation of its progress in this venture and enable other factors or trends that may impede performance to be identified.

According to the report "Organisational Stress in the National Health Service" (Health Education Authority 1995), information on initiatives to tackle organisational stress is limited. They believe that this is due to the fact initially, interventions are focused on the individual and their ability to deal with that stress and thus is not necessarily documented. It seems therefore that the organisation needs to identify aspects of organisational behaviour that may create stress and develop organisational solutions to achieve that. In the following chapter strategies that may assist both the organisation and the individual in this venture will be examined.

CHAPTER 4

ORGANISATIONAL STRATEGIES TO COMBAT STRESS

It has been established earlier within the thesis, that stress associated with working in the NHS is to be expected due to the nature of that work. However other factors also seem to have a part to play and they concern the organisational issues related to working in the NHS, particularly during this time of change. The effects of stress on an individual, irrespective of the cause and how this may impact on the organisation have been examined. Thus to ignore the dysfunctional effects of stress in the organisation could impair the organisation's overall performance and specifically in relation to the NHS, could result in a waste of public funds. The organisation needs to recognise its workforce as its most precious resource. To provide an environment in which employees feel nurtured and cared for could improve the health and performance of the employees and ultimately the organisation itself as a whole. According to Megranahan (1989), employers are often reluctant to admit that stress affects either their employees or the organisation. The reasons for this are not often clear but could relate to the culture of the organisation as mentioned in Chapter 3. Perhaps for an organisation to acknowledge stress exists, is to label itself as a poor employer.

It has already been mentioned that individual hospitals may incur costs in excess of £1 million a year due to employee absenteeism. (Seccombe & Buchan 1993) and that stress-related illnesses account for 40 million working days lost each year in the United Kingdom, (Powell & Enright 1990). It is possible that as a response to absenteeism and sickness rates and in line with its Health of the Nation strategy (Department of Health 1992), "Health at Work in the NHS" was launched in September 1992 (Department of Health 1992).

The initiative enables NHS organisations to "introduce a systematic healthy workplace programme that engages all staff in health promotion activities and builds on existing good practice" (Department of Health 1992). Implicit within this strategy is the suggestion that the workplace should have in place health promotion activities for staff, which will improve their well being. This should include strategies to reduce stress as a means to improve mental health at work Naylor (1995 : 4) citing Flanegan and Henry (1993) suggest that whilst an organisation cannot take responsibility for each individual's lifestyle, it does have a responsibility to provide work and work conditions that are conducive to health and high performance. An organisation that recognises that the nature of the work in which a large number of their employees are involved can create stress, should therefore be taking steps to reduce that stress. According to the Health Education Authority, most Trusts in the NHS have subscribed to the Health at Work initiatives[1]

[1] personal telephone conversation

The impact of the changes created by the recent organisation reforms, along with the lifting of Crown Immunity and greater employer responsibility for statutory sick pay, are some of the reasons that have increased the relevance of Health at Work to the NHS. The NHS Trusts now have to meet more of their own costs associated with sickness/absence from work. Any small benefit gained therefore by improving the health of employees could lead to substantial savings. However it may be that implementation of such strategies has an associated cost to the organisation. Will the benefits outweigh the costs?

Following on from the Health at Work in the NHS came the idea of Health Promotion Hospitals (HPH). To be part of the HPH movement certain expectations have to be met :

1. The creation of a healthy environment for staff and clients
2. Integration of health promotion activities into all activities of the institution
3. Creation of healthy alliances between the institution and other institutions resulting in a health promoting community.

(Department of Health 1994)

Explicit within these criteria is a high standard of care for the staff. It is important that not only is the individual considered within the organisation but also the general social setting. This brings in the role of the Occupational Health Department who can have a pivotal role to play in promoting health for employees. Not only are they available to monitor sickness trends, but they

can identify themes which may give an indication to the organisation as to the health impact and assessments of changes its decisions or patterns of work may have on the employee. A working environment which involves job overload, role conflict, role insecurity and lack of participation in the decision making, has been shown to influence employees' state of well being, especially psychologically. A health promoting hospital would attempt to take this on board and deal with it. The benefits to the organisation will be improved health and well being of both staff and the organisation.

Whilst the Health at Work initiative and HPH are concerned with health of employees in the widest context, this study is concerned specifically with stress associated with work. This chapter will therefore explore strategies that may assist organisations to reduce stress, including the role a counselling service may have in this venture.

Stress Reduction Strategies

Recruitment and Selection

Dunham (1988), suggests that with careful recruitment and selection the right person for the job is likely to be appointed. He recognises of course that this process is not infallible. However by ensuring a clear job description for the post, careful shortlisting, dependent on the information from the candidate and its applicability to the post, interview and decisions made in the light of the job description and person specification, a minimum level of mistakes will be made.

This notion of the "right person for the job" is supported by Ross and Altmaier (1994). They also suggest that some means to reduce the risk of stress after employment is to ensure the potential employee has a clear prior notion of what the job entails. One measure to achieve this is to offer "realistic job preview". The practice involves exposing the employee to the work environment before they are employed (Ross and Altmaier 1994 : 108). The belief is that the employee will gain an insight into the work involved. This did happen in some hospitals in the 1960s, in that potential student nurses were employed as "cadets" prior to commencement of their nurse training. The aim was to give them insight into nursing and what it entailed. As a result of this experience some cadets did leave before their training commenced having decided it was not for them. This practice of "pre training employment" has now disappeared. Some potential students do gain positions as care assistants/auxiliary nurses in the independent or NHS sector prior to commencement of training, but most insight into the demands of the profession now comes from discussions with those already in the profession, the media and careers centres, if at all.

Ross and Altmaier (1994) also suggest some form of "pre-employment testing" as a means to give information to suitability to the role. Birch (1975) offered the idea of personality testing prior to commencement of nurse training as means to reduce student attrition rates. These strategies may have something to offer as a means to reduce stress, especially if one accepts the notion that individuals are attracted to specific work cultures (infra page 52). Utilising such tools may reduce the numbers of inappropriately employed staff by matching individual characteristics which suit the job specification.

Whilst clear specification of a current role in the NHS can be given, what is difficult to anticipate is future trends. Nowadays to become

"employable" an individual needs to demonstrate their adaptability to change. As short-term or fixed contracts become the norm, flexibility appears to be the key. According to Knight (1995) individuals need to take responsibility for their own work, career satisfaction and job security, making sure their experience remains updated and relevant to current and potential employers.

Training and Career Development

Dunham (1988) goes on to argue that once an individual is appointed regular interviews with the employee should continue as a means to keep them informed of their performance. This kind of feed back has been linked to increased motivation and job satisfaction (Ross and Altmaier 1994). An effective appraisal system can assist an individual in the formulation of a programme which develops their skills as a means to help them and the organisation move forward. (Fullerton and Price 1991) By identifying personal training needs to meet the changing service, staff are able to improve their performance and feel a more worthwhile part of the organisation. By preparing staff to meet the changing service, potential is released. During times such as re-organisation and change, staff have fears for their jobs. An organisation that offers training as a means to prepare staff for these changes, utilises more effectively the available resource. Staff in turn feel valued by the organisation as they recognise their skills are still of use. At a time when the NHS is changing to meet purchaser and patient needs, staff need to be prepared to meet these needs. Knight (1995) supports this and recommends organisations take it on board by offering on-going training for staff. Staff

similarly must accept responsibility for their development and take the opportunities for development their employer offers.

Staff appraisal however can be stressful. Feedback on performance can be one way, it can be critical rather than constructive. An employee who receives only negative feedback is not likely to have motivation or develop job satisfaction. To this end managers need preparation for this role. Preparation needs to address the issue of the importance of constructive feed back to the employee. It should be a two-way dialogue aimed at development of the individual for the future rather than judgment of the past. This does not mean to say that negative behaviours should not be acknowledged, indeed in nursing this is crucial to ensure patient safety. However personal development plans should be designed which will aim to remove those negative behaviours and strengthen positive behaviours. These strategies have a cost in the form of training for managers, to undertake that role and the potential training needs of staff. However most of that cost could be reduced by using in-house expertise and the outcome is likely to improve employee performance, motivation and morale, thus improving performance of the organisation.

Stress Management Courses/Programmes

Stress management courses and programmes, aim at increasing an individual's ability to cope with stress by enabling them to develop their coping skills. In Chapter 1 an overview of how individuals cope with stress was given, stress management courses and programmes aim to maximise these individual resources. There is a view that the aim of stress management is palliative rather than preventive, developing skills to deal with stress when it occurs rather than developing skills to prevent stress (Ross and Altmaier 1994). Most stress management courses centre around further development

of an individual's own coping skills, e.g. time management and relaxation techniques.

Worthing Priority Care NHS Trust, had been examining the levels of stress present in their organisation and found them to be increasing. They therefore developed stress management courses to help staff deal with the symptoms, (Trust Network 1995). Evaluation of the courses showed that they did not tackle the cause of stress at work. Current practices had been that staff were "put through" a half day workshop which gave advice and tips on how to deal with stress, and then they went back to the environment that was causing stress. The survey identified factors within the structure and climate that increased stress. These were, poor communication, lack of role clarity and feelings of being undervalued. Middle managers also experienced all the pressures of their staff and were caught between the demands of the organisation and the staff themselves.

This resulted in the Trust changing their programme and concentrating its efforts on the following areas :

I. Improving communications and facilitating consultation and participation of staff in the decision making process.

II. Support systems. This included supervision for all grades of staff.

III. Positive feedback on performance, achievements and recognition of difficulties.

The approach taken by this Trust is to assist the individual within the organisation to work with the organisation in reducing stress. Not only are the employees encouraged to develop their own coping skills, but by using positive feedback and support systems through stress management courses, the Trust is attempting to demonstrate to employees that they are important within the

organisation, by acting on evaluations received as a means to improve the work environment. The organisation recognised itself as a potential source of stress for employees, and is attempting to do something about it.

In Chapter 3 the role of organisation structure and culture as a potential source of stress for employees was explored. It was suggested that within the NHS the stress related to organisational structure should be lessened, due to the more flattened structure and decentralisation of resources and decision making. However this does not seem to be the case. There is something about lack of preparation and cultural issues that seems to be aggravating feelings of stress and has been reflected in the Worthing experience. An organisation however that recognises itself as a potential source of stress, and is committed to reducing that stress, can utilise strategies such as stress management courses to identify those sources and trends that are causing stress and aim to reduce them. Whilst stress management may be "curative" rather than "preventive" it enables the employee to cope in the work setting whilst measures are employed that will reduce the underlying causes.

Work such as that by Pruitt (1992) support the idea of stress management courses to reduce stress. However, as with staff appraisal, there is a cost, particularly in the use of employee time. Employees need to be released from the work setting and facilitators need to be trained or employed to organise and run the courses or programmes. However if the relief they can bring to staff is to be acknowledged and that relief will improve work performance, then the cost maybe balanced with the benefits. Similarly if the information received from these courses enables those causes of stress to be reduced, then the benefits gained will outweigh the costs.

Support Groups

Support groups are valuable means of reducing stress at work. (McDerment 1988) They can assist individuals to gain a wider view of an incident than is otherwise possible. These groups are usually composed of individuals with similar experiences e.g. bereavement, dependent relatives. It allows individuals to share thoughts and feelings about their experience but also enables them to realise they are not alone. In the work setting these groups are generally uni-disciplinary (e.g. nurses) and aim at sharing the experiences. Support groups can be particularly valuable following a critical stress incident in the ward or department e.g. fire, major accident, death of a child. They allow the team to share and explore their feelings about the incident in a safe, controlled environment. They allow the group to gain a wider perspective of the incident by hearing others accounts. (Harvey 1992).

Historically, support in the NHS was primarily from one's own peer group of the same discipline. This not only offered support in time of stress but could be used as a resource. Support networks could extend from within the hospital to outside the hospital. Nurses came together to discuss nursing issues, administrators to discuss administration issues and so on. There was an understanding of each other roles. In the new NHS, this is no longer the case. A management team is comprised of different disciplines but all need to work together. To do this they need to develop a collaborative, working relationship and an understanding of each others roles. One means to achieve this collaboration and understanding is through team building.

The purpose of team building is to maximise the potential performance of the team. This may have spin-offs also for the individual. They can feel more a part of the organisation's function. They can develop an understanding of

other's roles within the organisation, resulting in a more conducive and supportive working environment (Munro 1995). This multi-disciplinary group could then become a support group in times of individual work stress. It is likely that if an individual within the team is experiencing stress at work, their colleagues are also experiencing stress. As with uni-disciplinary support groups, by team members sharing their perceptions a wider perspective can be achieved.

Support groups therefore do not necessarily need to contain members of the same discipline. However there may be times when this is appropriate dependent on a situation. What does seem to be important is the need for the team leader to be aware of the skills he/she requires to encourage the development of a healthy supportive team. These skills can be identified and included in personal development plans.

The Contribution of Counselling to Stress Reduction

So far a variety of organisational strategies have been described that can assist an individual to cope with stress at work or reduce it more effectively and/or lessen the stress produced by organisational factors. This section will explore the contribution a counselling service may also play in this function. Owen (1993), identified there was an increasing acknowledgment of the existence and significance of stress in health care services. However up until the late 1980s there was little systematic consideration of the organisational factors associated with stress, such as those suggested in Chapter 3. During the 1980s there was an increase in the popularity of counselling as a means to reduce stress. However these services tended to focus on treating the

symptoms rather than the cause, concentrating on helping individuals adapt to situations rather than changing those situations (Health Education Authority 1995). Whilst it is acknowledged that counselling cannot be a panacea for all situations or all individuals, if implemented effectively the service could not only help the individual but could also give valuable information to the organisation as to some possible causes of work stress.

According to Reddy (1985) counselling is "a set of techniques and attitudes which enables a person to solve a problem using his or her own resources" (Reddy 1985 : 239). However it could be argued that is also the role of stress management courses. Chapter 1 explored how stress can affect individuals. At times it can interfere with thought processes making individuals feel overwhelmed by the situation. Whilst stress management aims at enabling someone to manage those feelings, counselling takes that process a step further. Counselling is a process that aims to help an individual identify and clarify the issue causing the distress and to explore potential solutions in which those issues can be managed. (Megranahan 1989). It provides an opportunity for an individual to develop new coping and problem solving skills, allows the exploration of difficulties and encourages the setting of goals to deal with those difficulties, through self knowledge and personal growth (British Association of Counselling 1989). Simpson (1992) suggests in a similar way that counselling provides the time for an individual to develop those coping and problems solving skills.

To reduce feelings of stress, it appears from the literature reviewed in Chapter 1, that the personal skills needed include those of assertiveness, problem solving, developing of social networks through effective social skills, development of self esteem and an ability to activate personal coping

mechanisms. Proponents of counselling e.g. British Association of Counselling (1989) and Simpson (1992) suggest that counselling should be able to assist in the utilisation and development of these skills. Whilst assisting in symptom management and thus stress reduction, counselling has the potential to empower an individual to change some causes of stress.

Within America and latterly in this country, Employee Assistance Programmes (E.A.P.s), have been developed which offer counselling support to staff. (Tehrani 1994) Initially the counselling service was offered to those employees who were suffering the effects of substance mis-use, but in later programmes has been extended to include other problems such as those associated with emotional, relationship, work or legal issues. Some programmes also offer support to employees' family members. In these situations work was not necessarily the source of stress, but it was acknowledged that the stress experienced would be likely to have an impact on the individual's performance at work.

There are generally four approaches to Employee Assistance Programmes (Masi and Friedman 1988).

Internal Programmes involve the appointment of a counsellor by the organisation, who assesses and counsels employees. The organisation directly supervises the programme and designs policies and procedures. This approach has the advantage that the counsellor has a good working knowledge of the organisation and culture. The counsellor can more easily become known to the employees because they are based on the work site. There are disadvantages however, firstly, the perceived lack of independence from the organisation resulting in fears about confidentiality and secondly, the frequent restrictions on the counselling specialism available. Usually the skills are

limited to general counselling, with maybe one or two specialties. It is thus unlikely all employee needs can be met.

External programmes are offered when the services of a counsellor are contracted through an external agency. The advantages of this approach are increased confidentiality and access to a wider range of "specialist" counsellors than would be available in-house. The disadvantage is the possible lack of awareness by the counsellor of the influences of the organisation on a given situation. There is also the possibility that unless some feedback process is in place from the counsellor to the organisation concerning themes and trends, then underlying organisational issues related to stress will continue.

Combined programmes are a combination of both previous approaches. The organisation employs a counsellor who offers short-term focused counselling but can refer to external resources such as medical or specialist counselling networks. This enables the organisation to develop and operate standard counselling interventions whilst internal resources give organisational awareness of problems enabling rapid response to need and linked initiatives. Finally consortia arrangements can be used, usually by smaller organisations where resources are pooled to develop a collaborative programme to maximise individual resources.

Masi and Friedman (1988) suggest that management generally believes in-house programmes can provide a service at a lower cost with increased control and problem identification. External programmes on the other hand provide better accountability with reduced risk of legal liability. Thus help is provided but the employer is not directly responsible for "help" that maybe damaging. Consortia are seen as more difficult to run and have reduced control by individual organisations. According to Tehrani (1994) combination programmes, can manage resources in a cost effective way. Programme

administration is monitored and controlled internally and it is relatively easy to monitor, evaluate and analyse cost benefits.

Each organisation considering offering employee assistance programmes needs to decide what programme best suits its purpose. Whatever programme is chosen however must have the full support of senior management. This support includes the formulation of a policy statement and resource commitment. To ensure service efficiacy employees need to know of its existence, therefore effective marketing is also important. What is not clear from any of these programmes is how the organisation responds to the trends or issues that may be relayed to them. Is the counselling service purely to assist the employee cope with stress or does it inform the organisation of the part it may play in causing stress for employees? Does the organisation respond to this information thus potentially influencing organisational change?

A number of British companies have initiated programmes similar to the American E.A.P. model. For example, in 1986 the Post Office initiated a specialist counselling service (Sadu, Cooper and Allison 1989). There was already a basic counselling support service offered through the nursing and welfare officers but a more specialised service was recommended to deal with more complex problems. Previously employees with such problems would have been referred to external agencies, but it was assumed that an in-house specialist would have the benefit of a broad knowledge of the postal business and be better able to understand and help employees, particularly where the problem was work related. It was anticipated that the counsellor could advise on specific policies and procedures that were causing problems for employees, identifying themes and trends without the necessity of breaking confidentiality. Evaluation of the project showed positive results both from an organisational and individual perspective. Monitoring of sickness absence data showed an improvement in the mental health of employees and a marked decrease in the

number of days lost to the organisation through absence and sickness. Less dramatic was the slight rise in job satisfaction, organisational commitment and self esteem. However this was attributed to the newness of the project. Individuals were requested to complete questionnaires at their first interview and on completion of counselling. Analysis of these questionnaires would seem to suggest an improvement in mental health and self esteem after counselling which could account for the rise in job satisfaction and organisational commitment.

Other organisations such as DuPont (UK), Prince Computer (UK) and Nuclear Electric and many more have adopted some form of EAP or counselling service (Megranahan 1989). However until recently this service was rarely offered within the NHS. Some Occupational Health Departments offered counselling as part of their service but there was very little uptake. Now however more NHS Trusts seem to recognise the potential value of such a service. There are no estimates of the total number of Trusts who have initiated counselling services. However individual Trusts initiatives are increasingly being reported. For example St. Helens and Knowsley Community Health NHS Trust, (NHS Executive 1995) Leicester NHS Trust [2] and Nuffield Orthopedic Centre NHS Trust Oxford, (NHS Executive 1995) have established Employee Assistance Programmes.

Within St. Helens and Knowsley, a 12 month pilot was implemented in early 1995 and is an In-house scheme, with an externally trained counsellor who will provide short term telephone and face to face counselling. Their scheme is designed to provide employees with support in a "rapidly changing climate" (NHS Executive 1995). Their expectation is that absenteeism and employee turnover will reduce and individuals physical or mental health will

[2] personal telephone conversation

improve. Similarly, in Leicester, the Occupational Health Service initiated an Employee Assistance Programme. Evaluation to date suggests that absenteeism and employee turnover has reduced and individual physical and mental health has improved. Their programme, as with those initially started in America will also support family members of employees in times of crisis.[3]

Nuffield Orthopaedic Centre, working with external providers ICAS, initiated an EAP for 700 employees and their families in 1994 and have now renewed the programme. The scheme provides an initial telephone help line 365 days of the year. Up to 5 counselling sessions are also offered to individuals. Their programme uses an external information and counselling service and receives statistical data concerning trends and uptake from the agency. Ten percent of the workforce have used the scheme to date with half taking up face to face counselling. It is unclear from the article however, what service was used by the remaining employees, perhaps just the help line. Whilst initially the scheme aimed to demonstrate to staff that the Trust was a supportive employer, it has also achieved a reduction in absenteeism and sickness. The overall expenditure is less than 0.1% of employment costs (NHS Executive 1995).

From these four examples it can be seen that there can be benefits both to the employee and organisation in offering a Counselling Service. In all cases absenteeism and sickness reduced and physical and mental health seemed to improve. However what is not clear from the information is the number of staff who used the service because of work related stress. One could make the assertion that if the service brings benefits in reducing stress and improving health then the cause of that stress may be irrelevant. However if an organisation wishes to fund a service, they do need some idea as to the type of

[3] Personal contact

support to be offered, to ensure the service meets that need appropriately. Neither is it clear from the articles whether or not the organisations changed in response to information received from the service.

It is not sufficient to suggest a counselling service per-se is the answer. Counselling is not a satisfactorily controlled profession and so standards can vary considerably. Individuals using a counselling service deserve a considered and professional service. Milton (1993), suggests three requisites for this service, a trained and competent counsellor; an appropriate approach to counselling and a safe environment conducive to the provision of good counselling.

To accomplish this the organisation will need, either to re-deploy someone who already possesses these skills, fund training for someone or appoint a new member of staff. Staff costs are inevitably increased. Secondly accommodation will need to be found within or outside the organisation which again has a cost implication. Even if the service is to be offered by an existing department, resources must be found to enable that department to extend their service. The financial costs to the organisation of a counselling service however must be balanced with the benefits.

In addition if one accepts the premise that to admit to stress in the NHS, is to admit to a weakness, then employees will not use the service if they believe confidentiality is not protected. For that reason, whilst it is important that an organisation supporting such a service has some feedback as to the benefits, this information (such as statistics, themes and trends) must protect the anonymity of the service users. For a Counselling Service to be successful within an organisation therefore it is not sufficient just to offer a service. Counsellors need to be trained and competent to enable them to utilise

appropriate counselling theory in practice. The environment needs to be conducive to the process and confidentiality protected.

Finally, proper evaluation of counselling is both ethical and desirable as a response to demands from the organisation for evidence of "value for money". A counselling service, which is an expensive resource, that offers no evidence which demonstrates its benefits to the organisation or employee, will not generally gain continuing financial or other support from the rest of the organisation. Areas that need consideration during this process could be: counselling outcomes, service delivery and counsellor appraisal. These areas would give the organisation data concerning the benefits of the service to users and also give feedback to the counsellor on performance. Within the counselling outcomes could be means to identify themes and trends related to organisational behaviour, that may cause stress for employees. Presentation of findings must be clear and suggestions for change must be acted upon. There is little point in collecting such data unless this is the case. Commitment by the organisation and counsellor is paramount. A counselling service which does not give feedback to the organisation and an organisation that does not act upon that feedback is not assisting their employees or themselves.

In this chapter an overview of interventions which organisations such as the NHS could employ as a means to reduce stress has been offered. It seems that these strategies including that of counselling do have some part to play in reducing stress for employees. Some NHS Trusts which have initiated programmes such as counselling were identified. Their findings following implementation of these strategies, demonstrated improved well being of their employees and a reduced sickness/absence rate within the organisation as a whole. What is not so clear is whether or not the organisation themselves have changed as a response to the evaluations of the reported projects. Worthing Priority Care NHS Trust, following on from their introduction of stress

management courses, appears to have recognised that the organisation itself was creating stress for employees and is currently exploring ways in which it can change its structure and culture as a means to improve the working environment for staff and thus reduce stress.

There is evidence, based on the fact that many commercial organisations have adopted strategies to reduce stress (Megranahan 1989), to suggest a balance of costs and benefits to the organisation. These benefits include improved effectiveness, through reduced sickness/absence and an increase in productivity. However when introducing strategies such as a counselling service, the organisation needs to decide its rationale for such a venture. Is it solely to assist employees to cope with stress at work more effectively or is to also to give an indication to the organisation as to the causes of that stress? Whatever the reason it can only be successful if it is supported and driven by management at all levels in the organisation. The success of any service to reduce stress will not only be dependent upon management support but will be dependent upon staff using it. This requires effective marketing of the service and creation of an environment where to admit stress is not seen as a weakness. How this can occur needs to be established.

The literature reviewed so far has in part answered the question posed at the beginning of the thesis. However it has also raised other questions. The next chapter will describe the fieldwork undertaken as a means to gain more understanding as to the causes of stress, the influence of the structure and recent reforms on that stress and what strategies may reduce that stress, particularly for those nurses in a middle management role.

CHAPTER 5

The Research Approach

Introduction

The proceeding chapters of the thesis have reviewed the literature as a means to explore the following questions

1. What are the factors causing stress at work for nurses working in the NHS, particularly in a middle management role and how does that impact on their performance?

2. How far is stress aggravated by the organisational structure of the NHS and the recent reforms

3. How far and in what ways can the NHS as an organisation attempt to reduce stress for its employees.

4. Does a counselling service have an important role in such a strategy?

The literature reviewed included a brief resume of stress as a means to place the study in context. This was followed by an examination of the effects and management of stress by individuals. Then using the categories proposed by Cooper et al (1988) factors at work that can be associated with stress were explored. Whilst all factors could be seen to contribute towards stress at work for nurses in the NHS, not all could be clearly related to nurses in a middle management role. This posed the question therefore what are the factors that contribute towards stress at work for this particular group of nurses?

The literature reviewed suggested that particular forms of organisational structure and climate can affect the degree of stress experienced by employees. In theory there should be reduced stress now following the reforms due to its flattened structure and more involvement in the decision making processes for those nearer to direct client care. However this does not seem to be the case. This increased involvement appears to have brought problems related to role clarity and role boundaries, issues in themselves that are stressful. Are these the areas that are causing stress for nurses in a middle management role?

Stress has been shown from various studies to intefere with performance (Al Assaf 1992, Gardener and Gardener 1990). Therefore stress can have an impact on the organisation in both financial terms and in terms of effectiveness if the effects of stress in employees are not minimised. The organisation therefore may find it of benefit to invest in strategies that will assist employees to cope with stress, thus improving effectiveness and reducing costs incurred through sickness/absence and loss of productivity. A variety of strategies have been suggested, and indeed a counselling service does have a contribution to make towards stress reduction.

From the literature it has been suggested that the nursing culture is such, that to admit to stress is seen as a weakness. The question then is the extent to which any service would be used. The setting up of a service by the organisation has a cost. It is unlikely therefore, that the organisation will undertake this expense if there is no obvious return in the form of improved

output or reduced costs related to sickness/absence. It maybe for example that a counselling service could only operate successfully as part of a range of strategies to improve the working environment and conditions and not in isolation. Those strategies mentioned in the previous chapter as a package may encourage staff to believe the organisation is committed to their welfare, by seeing staff support as an integral part of its structure and function.

Whilst the literature reviewed does in part answer the questions posed at the beginning of the thesis, it only allows for generalisations to be made with regard to nurses as NHS employees. It does not address those questions specifically, in relation to the group of NHS employees on which this thesis focused i.e. nurses in middle management. As a means to explore these questions further therefore, field work was undertaken which involved a group of nurses in middle management and addressed with them the following questions :

- What are the factors causing stress at work for them?
- How does stress affect them and how do they cope with that stress?
- Is that stress aggravated by the organisational structure, climate and NHS reform?
- What strategies does the organisation or should the organisation employ to reduce stress in the workforce?

The results from the field was then compared with the information gathered from the literature. The following is an account of that process.

STYLE OF INQUIRY : QUANTITATIVE OR QUALITATIVE?

When pursuing any form of research it is most important to establish which style of inquiry will be the most appropriate. Bryman (1988), described in detail the fundamental characteristics of both quantitative and qualitative research. The following table is useful as an overview .

Table 6

RESEARCH	QUANTITATIVE	QUALITATIVE
1) Role of qualitative research	Preparatory	Means to, exploration of actors' interpretations
2) Relationship between researcher and subject	Distant	Close
3) Researcher's stance in relation to subject	Outsider	Insider
4) Relationship between theory/concepts and research	Confirmation	Emergent
5) Research strategy	Structured	Unstructured
6) Scope of findings	nomothetic	ideographic
7) Image of social reality	Theory, Generalisable, Static and External to actor	Processual and socially constructed by actor
8) Nature of data	"Hard, Reliable"	"Rich, Deep"

(Taken from Bryman 1988 : 94)

Bryman (1988), acknowledges that qualitative data may be used in both forms of inquiry. The quantitative researcher uses the qualitative approach as a means to prepare for the initial project. Its unstructured approach throws up ideas and hypotheses which can be tested more rigorously, using quantitative

methods where appropriate. However, for the purpose of this inquiry qualitative methods appear more appropriate as this study wishes to explore stress at work based on individual perceptions. It is the uniqueness of that individual experience that is important. The aim of the qualitative research is to enable us to understand social phenomena in natural settings the meaning experiences and views of those involved. (Pope and Mays 1995)

Similarly, according to Field and Morse (1990), qualitative research, should be used when;

"there is little known about the domain, when the investigator suspects that the present knowledge or theories may be biased, or when the research question pertains to understanding or describing a particular phenomenon, or event about which little is known"

(Field and Morse 1990:11)

Qualitative research strategies can be unstructured or loosely structured and predominately employ the methods of participant and non-participant observation, unstructured and/or semi-structured interviews with individuals and/or small groups of people. Data collected cannot be deemed as representative of the population at large, however it is inductive and like "Topsy" it grows developing theories, and those theories can give an emerging picture of society on which generalisations can be made. This is opposite to the quantitative researcher who attempts to obtain a "world view". The quantitative researcher concentrates on what are perceived as observed phenomena rather than on an individual's interpretation of events. To use this quantitative approach when exploring feelings is difficult and risks de-personalising the information collected. To answer the questions posed at the beginning of this chapter requires the researcher to explore in depth the

feelings of those involved and what factors created those feelings. A qualitative approach therefore was chosen.

THE RESEARCH STRATEGY

A strategy is needed to assist in collecting data. Strategies of inquiry enable research to be put into motion, directing the researcher to particular methods of collecting data. The research strategy that was employed for this study was that of phenomenology. Phenomenology's purpose is to describe particular phenomena as it is experienced by those involved.

Bryman (1988), citing Bogdan and Taylor (1975) described this idea of phenomenology :

> *"The phenomenologist views human behaviour ..... as a product of how people interpret their world. The task of the phenomenologist, and, for us, the qualitative methodologists, is to capture this process of interpretation ..... In order to grasp the meanings of a person's behaviour, the phenomenologist attempts to see things from that person's point of view.* ".
>
> (Bryman 1988 : 53) *emphasis in original.*

In my study I want to discover what stress means to those nurses working in a middle management role. How does stress affect them? What will help them or what can help them deal with that stress? I know how stress effects me, but I cannot presume it is the same for others. Nor can I assume the factors that cause me stress at work, also cause stress for others.

I also accept the phenomenologists' philosophy that we cannot objectify human behaviour. Omery (1983) cited by Field and Morse (1990) suggest that the main points to remember when using this methodology are :

1) Phenomenology is a descriptive approach to research

2) The objective is identification of the essence of behaviour

3) It is based on meditative thought

4) It's purpose is to promote understanding of human beings wherever they may be found

(Field and Morse 1990 : 28)

There are disadvantages to choosing to follow a phenomenological approach within qualitative research, generally concerning the issues of validity, reliability and bias. All research needs to be carried out in a critical, rigorous and systematic way to be of value, be it qualitative or quantitative in nature. To achieve this appears to suggest some form of scientific means of obtaining data which can be objectively analysed and validated. However when one is researching into the realms of individual feelings and behaviour this "scientific" stance becomes more difficult to maintain.

Reliability or dependability is the measure of the extent to which random variation may have influenced the stability and consistency of the results, (Field and Morse 1990 : 139) and to what degree the study could be replicated by another researcher following the same process. The attempt to address this issue of reliability will be discussed in the section concerning data collection.

Validity concerns the extent to which the research represents reality (Field and Morse 1990 : 139) The methods used in qualitative research aim to record the experiences attitudes and behaviours of those involved in the research. Therefore it could be argued that qualitative research can score highly on validity (Pope and Mays 1995). However to ensure that validity, the respondents involved need to be aware that the findings are a reasonable account of their experience.

In any social research it should be acknowledged that the researcher is inevitably part of the research process her/himself and the findings emerge from the interaction between the researcher and respondents. Bias must thus be acknowledged, while as far as possible preconceived ideas and notions are put to one side. Denzin and Linclon (1994) suggest that the researcher brings with them to the research process certain ideas, knowledge and assumptions which must be recognised and taken into account. The researcher must acknowledge that they can influence the process of inquiry due to the conceptions of self and others. I have inside knowledge of the NHS both before and after the reforms, as well as experience as a nurse and middle manager, because of that my interpretation of data collected therefore, is likely to be different from that of a researcher without that knowledge and experience. As with reliability bias can be a difficult issue to address. By making explicit my background, by describing the research process in detail and explaining how interpretation or conclusions were reached, an attempt has been made to reduce bias and maximise reliability. However it is acknowledged that to some extent the reader is relying on the integrity of the researcher in their account of the process.

Choosing The Sample Group

It is important when choosing the sample group that those chosen have experience of the phenomenon to be studied. In this case the phenomenon is the experience of stress by nurses working in a middle management role within the NHS. The size of that sample group also needed consideration. As I wanted to use a phenomenological approach and the data collection techniques that this requires, a large amount of data could be expected from each respondent. To keep that data manageable, whilst maintaining its depth, I chose to approach a group of nine nurses in a middle management role in a local NHS Trust. This I felt maximised the opportunity available to me for pursuing this approach whilst keeping the number involved manageable. The sample group consisted of both men and women, their ages ranging from between 35 - 50 years. Their professional experiences were varied.

The main advantage for choosing this group was that they fitted the criteria for this research "a purposive sample". They were also a group of nurses with whom I had worked with in the past and who knew me reasonably well and with whom I had had an effective working relationship. They were easily accessible geographically, allowing for easy contact should clarification be sought during analysis. Although we had worked together in the past, I was now a step or so removed from their working situation, which I believed would facilitate trust in as much the information they disclosed would not have implications for their work environment. If the culture is such that to admit to stress is a weakness, then this confidentiality is particularly important. Dreher (1994) suggests that a high quality relationship between the researcher and the respondents, based on trust and confidentiality, aids validity and reliability.

The main disadvantage of choosing this group however, concerned the issues of bias and reliability. Coming from a similar background with personal insight, involvement in the nursing culture and prior acquaintance with the sample group could influence the conclusions made. As a means to address those issues an interview tool was designed for data collection and is available to be used by other researchers. A detailed account of the process has been attempted and within the analysis, comments from the respondents have been included in the commentary, as a means to give the reader some rationale for the direction taken and the process of thinking of the researcher.

RESEARCH TECHNIQUES USED

Having decided upon the research approach, it was necessary to decide the techniques to be utilised. I chose interviewing. Firstly the group examined and the focus of this study could not be easily observed from a practical point of view. Secondly the length of time available for the piece of work was limited. According to Ely et al (1991), participant observation is essentially about looking and listening. This technique requires large amounts of time. If I was to study a group of NHS employees and to spend time observing them in their role, it would take more time than I had available. I also wanted the participants to identify their own periods of stress and it could be, if I was observing, what I thought to be a stressful situation may not have been so for the participant and would need to be explored through interview anyway. It is the participants perceptions that are important during this time, not mine.

Qualitative research "allows the opportunity to talk with people" (Ely et al 1991 : 57). Using an interview format appears to be a useful tool to initiate conversation. The major purpose of the interview is to hear what the

participants have to say and how they interpret what is going on around them. I chose to interview those involved individually. The study was concerned with individual feelings and behaviours and although the analysis does explore how far patterns seem to emerge collective responses were not wanted. Based on the literature reviewed concerning the culture of organisations, I was also very conscious that the acknowledgment of stress at work was a sensitive issue and participants may not be willing to speak freely if their peers were present.

With regard to the interview, I chose to design a semi-structured format. Semi-structured interviews or guided interviews employ a set of themes and topics to form questions in the course of conversation, giving participants an opportunity to develop their answers outside a structured format. This allows more freedom both for researcher and respondent than totally structured interviews, allowing for probing and pursuing of points made, but has structure to ensure that vital areas are covered. This involves having a carefully planned overall framework of questions. A lot of thought needs to be given to devising questions to adequately reflect what the researcher is trying to find out (Cohen and Manion 1985).

I also considered the time factor. I expected to have restricted time in which to conduct the interviews and I wanted to use this time to the best advantage and felt a semi-structured interview was a means of utilising more effectively the time available.

Ethical Consideration

Fontana and Fry (1994) address the ethical considerations of research. The objects of the inquiry are human beings and thus care must be taken to avoid any harm to them, either physically or emotionally. They talk of informed consent, ensuring the participant is fully aware and has been truthfully told about the research. The participants also have the right to privacy, which they interpret as protecting the identity of the participants.

According to Fontana and Frey (1994), the presentation of self in a situation such as this is very important. I approached each participant, told them what I was planning and why and asked if they would be willing to take part in the field work. All those approached agreed. I attribute this willingness to help, partly due to the fact they knew me and we had worked in a mutually respectful environment in the past. We had shared experiences and problems and helped solve them together. I presented myself as friend and colleague with this piece of work to do, and although it was not directly concerned with our working lives they were willing to help. I also asked their permission to tape the interview. This permission was given.

Ely et al (1991), identify honesty and trustworthiness as important personal qualities of the researcher. According to them "being trustworthy" as a researcher means at least that the processes of the research are carried out fairly, that the products represent as closely as possible the experiences of the people who are studied (Ely et al 1991 : 93). This was a reason I wished to tape the interviews, to ensure I could represent as clearly as possible the participants' experiences.

Confidentiality related to the sample group has briefly been alluded to, but was an important aspect to consider. I took great pains to ensure confidentiality. Initially I was to ask a colleague, unconnected with the research to transcribe the tapes but as will be explained later I did infact transcribe the tapes personally. The tapes and transcripts would be destroyed once the work was successfully completed. Similarly, although the group was composed of both men and women, all were given female pseudonyms in the analysis. Men are a minority group in nursing. To associate their gender with some of their comments could lead to their identity being discovered, especially if the work was to be read by a colleague in that Trust. However if a gender issue arose that would need to be acknowledged. The NHS Trust for whom the group worked was not identified.

I recognised that the close personal interaction generated in the interview, may produce for the respondents problems of confidentiality and anonymity. Therefore I agreed to send my findings and interpretation of their own interview to them which allowed them, the opportunity to ensure they had not been misrepresented or misunderstood. I wanted to reassure them there was no hidden agenda and offering them access to my findings and interpretations was one way to achieve that. This is also a means to increase validity. All participants received copies of my interpretations of their interview, not one contacted me to say they were unhappy with the interpretation. I therefore continued with the analysis.

Collection of Data

To gain understanding the researcher must establish rapport. Close rapport with the respondents opens doors to more informed research (Fontana and Frey 1994). Rapport would be initiated through the interviews. However

close rapport may create problems if the researcher becomes too close as they could end up the spokesperson for the group. This I did not feel would be a problem due to the individual nature of the style of inquiry.

Having decided to use a semi-structured format for the interviews it was necessary to design the questions as a means to collect the data. To enable this process the suggestion of Cohen and Manion (1985) to identify themes to be explored was considered. There seemed to be two main themes, one concerning stress and its effect on the individual and another concerning stress at work and the role of the organisation. I therefore produced questions which I hoped would generate conversation around these two main areas. However I felt I needed to help the participants focus on their feelings and behaviours when they did feel stress, therefore I included a third section in the interview related to this.

The first part of the interview attempted to establish if there was some common understanding of the term stress and whether life today was generally more stressful. The second part of the interview was more concerned with the individual responses to stress, their feelings and behaviours. To assist the participants to focus on these feelings and behaviours I showed them a list of stressful life events complied by Holmes and Rahe (1967), and cited in Rice (1992). (Appendix 1) The participants were asked to look at the list and identify an experience that had evoked feelings they considered to be associated with stress. If there was no event on the list which was relevant to them, they were asked to identify one. The questions were designed to enable them to describe the feelings and behaviours they experienced during that time. I also wanted to ascertain how during this stressful time the participant had dealt with those feelings. Did they use their coping skills, did they seek outside help? I included therefore some questions designed to gain that information. I appreciated that there may be feelings re-generated that had

been hidden or suppressed and I expected my counselling skills to be of use if and when that occurred. I needed to remember that this was a research interview and not a counselling session but if a participant became distressed that could not be ignored.

The final part of the interview concentrated on stress at work. I hoped that as the participants awareness of stress had been raised, they would be able to focus upon situations at work that generated similar feelings. I was also keen to test out my assumption that counselling would help in these situations, so I included questions related to sources of help. From the literature reviewed it seems that the organisational structure and culture can exacerbate feelings of stress. So I also included questions to find out if this was the case. Was it legitimate to admit to stress and if so how did the organisation, if at all, respond to employee stress?

Asking questions is not as easy as it seems. I wanted to use open ended questions as a means to gain as much information as possible. The questions needed to generate information about the participants perception of stress in these three areas. I produced therefore, what I have termed an interview schedule in three parts to be used as a framework. (Appendix 2.1, 2.2, 2.3) The interviews were subsequently transcribed. The use of a tape recorder avoided the chance of missing anything and represented closely the responses of those involved. I thought if I tried to note points during the interview, not only could it interfere with the dialogue, but I could also miss other important points. It also allowed me to listen again to the interview and with the transcript make note of aspects such as, tone of voice, humour, sadness. Ely et al (1991) see these notes as the beginning of the analysis. It also gives an opportunity for the researcher to reflect on their part in the process. However it is necessary to distinguish between the two.

I recognise that I shared the culture of nursing and could very easily make assumptions about what was being said. The use of the tape recorder recorded what was actually said, not what I presumed or remembered had been said. I needed accuracy throughout the field work and this was a means of achieving that. I used my counselling skills during the interviews to assist me in collecting the data. Although I had attempted to design open ended questions for the interview schedule, sometimes the responses required further clarification. I used therefore some of the counselling skills proposed by Egan (1986), concerned with exploration, primarily verbal and non-verbal attending. When collecting data I was actively encouraging the participants to explore their feelings and behaviours associated with stress and stressful events. The skills proposed by Egan (1986) of non-verbal and verbal attending therefore are particularly useful. They are non-directive in nature and aim to encourage the person to talk out their feelings. Field and Morse (1990) caution against the use of counselling skills in the research interview, seeing them as a hindrance, in some way making it easier for the informant to agree with the researcher. I would argue that this could happen in any interview. What these skills do is assist the researcher in their interview technique to improve conversation by attempting to be non-directive.

Throughout the collection of data and during the analysis I was constantly aware of the differing roles of researcher and counsellor. The skills I had developed through my counselling training, assisted me to collect data by encouraging the participants to talk during the interviews, but I had to stop myself from becoming involved or too close to the participant. This is contrary to counselling training, when the feelings experienced by the counsellor can often assist in the process. There is also a difference in the expected outcomes from the counselling interview and the research interview. The counselling interview aims to provide insight for the client, whilst the research interview is aiming to provide insight for the researcher. Conflict however can arise if the

counsellor/researcher re-generates past feelings, these cannot be left unaddressed. In what way or how does the researcher react? I agreed with the participants that should this occur we would stop the tape. Only when the participant felt willing to proceed would we do so. If they felt unable to continue then that interview data would not be used. Only once did this occur (with Deborah), but after a short while we re-commenced the interview and completed it.

The Actual Process

The first step when starting the data collection was to "test" the interview schedule to ensure it generated the data anticipated. Deborah and Elsie were approached initially having been selected at random. These, as the other interviews, were conducted away from the work environment in a pleasant setting with easy chairs. It was important to make sure the participants were physically comfortable to facilitate conversation. We also agreed they would leave their "bleeps" with someone else for the length of the interview. This was important, as I wanted the participants to discuss their feelings in an environment free from interruptions and as relaxed as possible. This would not be achieved if they anticipated they may be called away at any time, especially if they became distressed. It would be unkind, if not unethical, to put them in a position where they had to return to the work situation in a distressed state.

Interviews were planned to fit in with the participants' working day. Following the interviews I transcribed the tapes myself. My initial thoughts had been that I would ask an audio-typist to transcribe the remaining interview tapes. It was when transcribing the first interviews however I realised I wanted to do this personally. Not only did it increase confidentiality, but it allowed me to make notes alongside a particular response as I heard it. With

hindsight, this could have been achieved even if someone else had transcribed the tapes. However I do feel that listening and reading may result in some loss of acknowledgment of intonation or emotion during responses.

It was during the interview with Deborah I had to stop the tape. She become quite distressed when discussing a personal loss of many years earlier. She revealed that she hadn't really discussed these feelings before and we gave time to do that. When Deborah felt able to continue we did so. It was during the interview with Deborah I realised as we moved towards the end of Part 3 of the schedule, that she had not mentioned the use of a counselling service as a response to question 10 - *How would you like the organisation to respond to stress?* (Appendix 2.3) I therefore needed to ask about counselling directly, as my initial starting point had been to explore the contribution of counselling to stress reduction. She had mentioned other strategies and behaviours arising that may be able to help individuals working in the organisation to cope with stress, but not counselling. I had not initially included within the schedule a direct question related to counselling. I assumed it would be spontaneously mentioned by the participants as a strategy for stress reduction.

I waited until after my interview with Elsie before I added questions 11 to 14 to Part 3 of the interview schedule (Appendix 3). I did find that I needed the questions ready for this interview because, as with Deborah, counselling was not a helping strategy spontaneously mentioned by Elsie, even though she had used a counselling service herself in the past. In other respects, the two pilot interviews went well and thematic analysis of the data collected from these two interviews, elicited a range of relevant data. I decided to aggregate this data with the rest and analyse all the interviews together when completed.

It was during the analysis of these first two interviews that I gained an impression that the details related to factors at work which cause stress, were

not as clear as those related to personal experiences. I therefore used the suggestion of one of my supervisors, that I ask the remaining participants to use a diary or journal and note down situations at work that caused them stress on the day they occurred. I contacted the remaining participants and asked if they would be willing to do this over the next month. We then provisionally booked interview times for a month later.

There was one individual who I wanted to include, but delayed in approaching to ask her to be involved because I knew she was currently experiencing some personal trauma. I knew the person well enough to know they did not like their personal life "investigated" and I did not want to appear "nosey". I eventually decided to approach this person and allow her to make the decision. If I had not approached her she would have been the only nurse manager at that level in the Trust not approached. Not only would that reduce the size and range of the sample, but it could make her feel "left out". In the event, she agreed to be included. (See footnote) [4] Due to my hesitation, there was insufficient time for that person to keep a diary of events at work that were stressful, but she talked very freely during the interview and focused readily on feelings related to events.

When the interviews took place, the first few minutes were spent in helping the participants to relax and feel at ease. It was useful to have coffee and tea facilities available as this made the situation less formal. Whilst I made the tea and coffee we chatted generally during which time the tape recorder was running to enable the participants to get used to its presence. Most seemed quite relaxed, possibly due to the fact that they knew me well,

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To maintain confidentiality I had not informed individual participants who the others were who were involved in the study. However, I do know that they told each other at informal and formal meetings that they were helping me with the work. I however did not discuss who was involved in the study with individual participants.

and felt comfortable enough to discuss the subject with me. Using the interview schedule was useful. Often however, one question elicited responses which answered subsequent questions and so on. Avoiding leading questions was necessary, but sometimes, because questions had been answered out of sequence I needed to rephrase them. The only obvious leading questions were those towards the end of Part 3 of the schedule, concerning a counselling service. Given my initial interest I wanted, and needed to know their feelings about a counselling service as a means to reduce stress for employees in the NHS. At the end of the interview I thanked them for their help.

The interviews lasted an average of about 50 minutes and were worthwhile, producing a lot of rich data. One "flowed" less easily than the others, the interview with Liz. I can only hypothesise as to the reasons for this. All participants had known me for the same length of time. In the hierarchical structure I was senior to most of the respondents, including Liz. This for Liz I felt inhibited the openness during the interview and I was only trusted with personal details that were not current. Indeed even in Part 3, when discussing stress at work, she kept away from very personal issues and made generalisations, using the term "we" rather than "I", "everyone" rather than "me". Did Liz believe that as I held a more senior position in the nursing hierarchy I would make value judgments about her if she acknowledged stress? The notion of a hierarchy in an interview situation has been suggested by Fontana and Frey (1994), the respondent being in a subordinate position. What appears to be conversation is in fact a one way flow of information, with the interviewer giving little if nothing back. Was this the case for Liz? It is difficult to decide as to the reason but interesting to note how perhaps hierarchies from outside, may influence the research interview.

It was very clear on conclusion of the interviews that my initial thoughts needed to change. Not one respondent had spontaneously mentioned a counselling service as a response by the organisation to reduce stress at work. My exposure to the respondents personal experiences had changed my mind. As will be seen from the data analysis a counselling service may have a part to play in this area of stress reduction, but perhaps only as one of a number of strategies organisations could employ.

Data Analysis

Having collected the data the next job was to analyse it. I chose to use thematic content analysis as described by Burnard (1991). Thematic content analysis, is an examination of the data, grouping together themes, coding, classifying and categorising them and has been adapted from Glaser and Strauss (1967) grounded theory approach and various works on content analysis (Burnard 1991). According to Burnard, no one method of analysis can be used for all types of data. The method he describes assumes semi-structured interviews or open ended interviews were recorded and transcribed in full. The underlying assumption of this process however, is that one person's perception of a phenomenon can be linked with another. Which may not always be the case. Similarly there is the subjective nature of the coding system. However the process offered by Burnard (1991) was sequential with a series of stages to be followed which did give some structure to the process. The assumption that there could be links between individual perceptions of a phenomenon was accepted because the literature that had been reviewed related to stress and its effects, seemed to suggest this was possible. The issue

as to the subjectivity of the coding was addressed by involving a colleague when the process was completed (supra page 101). In my naiveté I did not imagine how time consuming this process would be. Following transcription of the interview I sat down quietly and read them through. I then read them again to try to identify the themes around which the interview had been designed. The next stage was to identify key categories related to that theme and then sub categories related to that key category.

At first I seemed to be using very little of the data and I was concerned that I was not going to be able to make any interpretations. However once I identified the themes I colour coded with a pen the key categories. This then started to identify how responses to questions in different parts of the interview, contained aspects that were pertinent to the themes. All sections of the interview ended up with different colour codes within them. Responses were then cut up and pasted according to their colour code and pertinent categories i.e. theme, key category and sub-category (see table 7).

TABLE 7

EXAMPLE OF HOW DATA INCORPORATED INTO KEY CATEGORIES AND SUB HEADINGS ISSUES RELATED TO THEMES

THEME :	EFFECT OF STRESS
KEY CATEGORY :	PSYCHOLOGICAL EFFECTS OF STRESS
SUB CATEGORY :	1) Loss Of Control (4 Respondents)
Jean :	*A state or a feeling when you haven't got complete control. Not being able to see how you are going to get back into the driving seat.*
Liz :	*Stress is when you are not coping properly when you feel out of control.*
Beverly :	*I would see stress as being out of control because there are things you can't bring in for it being all right for you.*
Deborah :	*Stress for me is that I'm not going to perform and some things are out of my control.*

Once I had completed this listing of responses under categories I re-read the original transcripts to ensure they were in context. Some minor adjustments were made. As a means to increase the quality of the inquiry and validity copies of the transcripts were given to a friend to identify his own categories. He had no contact or knowledge of the respondents. We then discussed our findings and refined a final category list. There were few differences in our categorisation. Using this method ensured all information relating to specific themes was together. This then formed the basis of the

interpretation of the results. It was also an important aspect of strengthening reliability and validity in this qualitative research.

During this process decisions needed to be made as to whether all data is to be included or whether some should be excluded, particularly what Burnard (1991) refers to as "dross". He gives an example of such

> *"I don't know, like they say, now they say it was all right, whereas before, perhaps, you wouldn't"*
>
> (Burnard 1991 : 464)

Dross is data from which no information can be extracted. There was very little in the way of "dross" within the responses. What was there was highlighted and shared with my friend to ensure no information could be gleaned from it, it was then not used. What was difficult to decide was which responses to include in the text itself without it becoming a collection of quotes. We crudely ranked the responses therefore for clarity of meaning and used only one or two to emphasise a point but referred to the actual number of responses in that area. For example in Table 7 four respondents referred to loss of control, but only Jean's response was used in the actual text to demonstrate this point.

It is the interpretation of this data following analysis which will represent the reality for the participant group or individual. The clarity of this interpretation is crucial to the task of validity. By explaining in detail the

process undertaken, referencing my interpretations with literature as far as possible during the analysis, hopefully has given some clarity to the reader.

When reporting quotations from the data to illustrate an issue or concept, it is important the reader sees this in context . For that reason the style of quotation was adapted from Field and Morse (1991) (see appendix 4). This style allows for pauses in the conversation to be demonstrated, explanations and illustrations by myself to be included, which keeps the response in context and grammatical errors acknowledged.

The final stage in the process of analysis is to offer conclusions and suggestions of the way forward. This necessitated writing and re-writing the analysis as a means to give some coherence, conclusions and suggestions are given in Chapter 8 and attempt to highlight the key issues emerging from the interpretation.

The Analysis

CHAPTER 6

PERCEPTIONS OF STRESS

Introduction

The next two chapters record the findings of the data analysis. The first of the two chapters is in two parts, A and B. Part A provides information concerning the respondents general perceptions of stress in today's society. What it is that causes stress, how it can be recognised and how they believe stress can affect individuals. Part B of this chapter describes how the respondents themselves are affected by and manage a stressful situation. The following chapter will examine the concept of stress at work. What factors at work cause the respondents stress, how they manage that stress and how they see the organisation managing stress. Conclusions will be drawn at the end of each section related to the findings. Overall conclusions and implication of the findings will be made in the concluding chapter.

Using Burnard's (1991) thematic approach to the analysis the following themes were identified :

The causes of stress

The effects of stress

The management of stress

Each one of the above themes was explored in the three sections of the interview concerning :

I. The general awareness of stress in society

II. The personal experience of stress

III.Stress at work

Part A - General Perception Of Stress In Today's Society

As a means to ascertain the meaning the respondents attach to the concept of stress, the first section of the interview posed questions associated with stress in society. Did the respondents for example consider life was more stressful than twenty years ago. If so what did they consider to be the causes of this? How could they recognise stress in others?

Seven respondents stated very clearly that life was more stressful today. Two respondents were not sure, but felt younger people may feel that it is so,

Audrey : *"I don't know, I think there are perhaps more pressures on young people particularly on children. Pressures to grow up quickly".*

Elsie : *"Personal opinion .....I don't really think so, I think the older you are you handle things better. So when I was thirty I did feel more stressed than I do now at fifty because I feel I've got life experience and probably handle things better"*

Elsie makes an interesting point, that with age and experience a person can deal with stress more easily. Past experience of a given situation helps us deal with stress when and if we meet it again. This could be considered part of the learning process as proposed by Farmer Monohan and Hekeler (1984), in as much we learn how to cope with stress from our parents and from behaviours that have shown to give relief in the past. This is contrary to Cooper et al's (1988) opinion who suggest age can aggravate or exacerbate stress.

Table 8 gives a list as to why the respondents perceived that life today could be considered more stressful

TABLE 8

FACTORS CAUSING STRESS IN SOCIETY

i)	Work	(9)
ii)	Want to have the same as everyone else	(4)
iii)	Less tolerant society	(4)
iv)	Isolation, nuclear families	(2)
v)	Financial worries, role reversal, jobs	(1)
vi)	Changes in patterns of disease	(1)

Table 8 shows work was perceived as the most common stressful event.

In table 9 the aspects of work which the respondents considered to be stressful are identified.

TABLE 9

GENERAL PERCEPTIONS OF FACTORS ASSOCIATED WITH STRESS AT WORK

i)	Greater expectation of people	(5)
ii)	Faster turnover/(of product)	(4)
iii)	Job insecurity	(4)
iv)	Competitiveness	(3)
v)	Greater pressure on individuals to achieve	(2)
vi)	More complaints	(1)
vii)	Business orientation	(1)
viii)	Lack of sharing with peers - isolation	(1)
ix)	Change	(1)

(The number of references to each item is in brackets)

CAUSES OF WORK STRESS

Greater expectation of people was mentioned by five respondents. One could link this item with items v and vi in table 9. Is it more important now-a-days for people to achieve and that drives individuals? Does this in turn make them feel that others have high expectations of them? Sheila would think so.

Sheila : *"We are under greater pressure to achieve, to get an outcome in order to stay in a job"*

Linking pressure to achieve with increased complaints can increase feelings of stress. Within the NHS at the moment, as part of the Patients Charter and quality initiatives, complaints are actively encouraged. Thus the pressure to achieve and perform effectively is greater.

Liz linked greater expectation with change and job security.

Liz : *"I think change, all the changes have a lot to do with it and people are very unsure of their positions"*

Job insecurity, faster throughput of patients and competitiveness have been referred to in previous chapters as areas that can create stress in the current NHS with its new business orientation. It appears that the respondents are referring to similar areas when discussing their ideas about factors that can be associated with stress at work. In part three of the analysis these areas are referred to again when discussing their personal experience of stress at work.

Lack of sharing with peers and feelings of isolation were mentioned by one respondent as a cause of stress at work. It has been identified in the

literature (Cooper et al 1988) that sharing with peers is a means of reducing stress. Is it the lack of this facility that is causing the stress or that the lack of this facility makes it impossible for an individual to discuss issues that are causing them stress?

Some links could be made between Table 8 and Table 9, suggesting that what is happening in society can reflect the work environment and vice-versa. For example, the development of nuclear families and lack of peer support at work can both lead to feelings of isolation and thus stress. A less tolerant society suggests greater expectations of people. Wanting to have the same as everyone else, could be reflected in competitiveness.

Surprisingly financial worries was only deemed a stress factor in society by one respondent in Table 8. Job insecurity which could result in financial worries was mentioned by 4 respondents as a cause of work stress. Is it rather that the loss of self esteem associated with job loss is more stressful than the related financial worries?

Only Sheila mentioned the changing pattern of disease and the fact this could increase stress in society. People are dying of "new diseases" at a younger age but due to increased knowledge and technology people are also living longer putting a strain on both society and family resources.

Sheila : *"We are in a demographic position where we are providing a lot of care for patients at the top end of the age barrier. New diseases affecting middle age are leading to bereavement for the partner left"*

With the exception of item vi in Table 8 most factors related to stress in society seem to be linked to work. Their perceptions as to why this is so has

been identified in Table 9. Those factors can also be linked to the changing pattern of health care in the acute service. There is a faster turnover of patients for example, an increase in day surgery. The reduction of waiting lists is being used as an indicator by the Government of a Trusts performance. This throughput increases the workload for staff. The purchaser, provider split and the implementation of the contracting process, increases the competitive nature and business orientation of the Trust. The NHS reforms therefore do seem to be increasing stress for employees in the NHS as suggested in previous chapters. Stress in this case, being caused by the increased work load as a result of the contracting process and meeting government targets.

The Effects of Stress

According to the literature stress can affect an individual both physically and psychologically. Can these effects be recognised by others? All respondents were able to describe the affects of stress on an individual either physically and/or psychologically. They all believed that the cause of stress came from an external event, supporting the notion proposed by Rice 1992. (infra page 10)

Physiological Effects of Stress

The physiological effects of stress were mentioned by four of the respondents. All four however thought these effects to be less important initially than the psychological effects of stress. They suggested that the long term effects of psychological stress could lead to physiological effects but that the psychological effects were more difficult to deal with.

Sheila : *"it produces two types of symptoms psychological and physical. I kind of think, my own personal view is that dealing with the psychological ones is often more difficult.*

One respondent included pre-menstrual tension in the physiological effects of stress, suggesting that woman's ability to cope with stress was reduced at particular times of the menstrual cycle.

Deborah : *"As a matter of fact what also has an effect is the time of the month. I know sometimes I can have a couple of days when a bomb could drop and I wouldn't be bothered. Other times ....."*

Deborah goes on to say that her female colleagues around the same age complain of similar problems and because they work together can exacerbate each others feelings.

Deborah :" *I think sometimes we bounce off each other and cause each other stress because we are all at the wrong time of the month"*

Deborah seems to be suggesting here that a woman's reduced ability to cope with stress can aggravate others who may also be pre-menstrual at the same time, making them all more emotional and unable to cope effectively. There is research exploring Deborah's suggestion as to the link between Pre-menstrual Tension and emotional response. (Fontana and Pontari 1994) At the moment there is insufficient accepted data but, in a female dominated profession such as nursing, the findings of such work needs to be considered.

In the main however the respondents concentrated on the accepted physiological effects of stress as described by Seyle (1978) concerning the physical effects of adrenaline release.

Liz : *"You feel very agitated, heart racing and the like"*

Beverly : *"physically you get all the anxiety elements that come into it"*

Psychological Effects of Stress

All nine respondents mentioned in great detail the psychological effects of stress. These could be broadly catergorised as :

i) interference with performance
ii) interference with thought processes
iii) being out of control
iv) effects on self esteem

These findings correspond to the literature. For example according to Parry (1990), stress can affect the way we think and our concentration, this in turn can interfere with our work performance, making us more impulsive in our decisions and interfering with our ability to cope with stress.

Six respondents identified issues related to interference with performance. Although this particular section of the interview was concerned with the general awareness of stress the respondents often personalised it.

Helen : *"Stress to me is when I can't function as I would normally do, where there is (sic) changes in how I would normally*

function, some external force that's caused a change in my behaviour".

Six respondents also stated that stress could interfere with their thought processes. An assumption could be made that this interference with thought processes could also result in an interference with performance. This link was not made by the respondents. However both situations do appear to have a negative effect on an individual as Audrey specifies.

Audrey : *"too much of it [stress] means there are demands made on you that you cannot meet. [performance] The stressful thing is actually prioritising things in order, [thought processes] trying to juggle 'loads of balls in the air at one time*".

Four respondents mentioned this loss of control, Jean most clearly.

Jean : *"A state or a feeling when you haven't got complete control. Not being able to see how you are going to get back in the driving seat*".

Being in control is a coping style suggested by Rice (1992), and supported by Meichenbaum and Calman (1983). If an individual believes they can exercise some control or influence over a situation then their level of stress is reduced. It also supports Phares (1991) notion of internal and external control.

Positive self esteem according to Rice (1992) is a coping resource. High or positive self esteem has been correlated with low levels of stress. Deborah

suggests that the expectation an individual believes others have of them, can interfere with self esteem.

Deborah *"It's the worry of not being able to perform that causes the stress. Self esteem comes into it, you think you can't match the expectations others have of you".*

Whilst the effect on self esteem and its relationship to the expectations of others was only mentioned here by Deborah reference to this is made later in the analysis by other respondents when discussing stress at work.

Having described stress and its effects, all respondents were asked if they thought these effects, (physiological or psychological) had a positive or a negative effect on an individual. If stress has a positive effect on someone there would be no need of a counselling service or any other service as a measure to reduce stress. Seven respondents recognised that an optimum level of stress had a positive effect and could indeed improve performance as suggested by Al-Assaf (1992). All seven however, stated that this level of stress varied from individual to individual and questioned when one knew they had passed their optimum level of stress.

Beverly : *"I think stress is dependent on how much adrenaline you have going, the adrenaline part of if can actually be helpful because you work at a quicker pace, it can be very positive. It becomes negative when the pressure gets so much you can't actually cope, finding that optimum level is quite difficult".*

Audrey : *"You can't make generalisations, what one person finds as stressful someone else may thrive on".*

Two respondents stated they always thought of stress as negative in its effects. This suggested that stress irrespective of its level was always negative in its effects for them.

Deborah : *"With me it's negative because if I am stressed I don't perform well"*

Marion : *"It's negative. I end up running around getting nowhere".*

All nine respondents could recognise when someone they knew was experiencing stress. They were able to give reasons as to how they arrived at that conclusion.

There were two categories mentioned :

I. Change in the behaviour of the individual

II. Knowledge of the person or their situation

With regard to change in the individual's behaviour, the respondents referred mostly to the psychological changes in behaviour. These included such things as someone being more easily upset or conversely withdrawn and uncommunicative. They also made reference to changes in work performance due to lack of concentration or confidence. The changes in others that the respondents detected are identified in Table 10. The main change identified was that of being "over reactive". This it transpires is when an individual who they is believe to be stressed, reacts inappropriately to a situation. For example they become angry at a simple request or an inanimate object. They seem unreasonable in their behaviour.

Table 10

Recognition of Stress in Others	
i) Over Reactive	(5)
ii) Memory Lapses	(4)
iii)Irritability, Short Tempered	(4)
iv)Lack of Confidence	(3)
v) Easily Upset	(2)
vi)Loss of Concentration	(2)
vii)Making Mistakes	(2)
viii)Obstructive and Negative Opionions	(2)
ix)Depression	(1)
x) Withdrawn	(1)

(The number of references to each item is in brackets)

Secondly, the respondents mentioned that it was more likely you would recognise these changes more readily if you knew the person well or knew the situation they were experiencing. For example :-

Sheila : *"We've got (sic) stress in 110 staff this week. We've just had the outcome of the profile exercise and there are parts of it that are unpalatable, resulting in job insecurities".*

Similarly if you know someone well you are more likely to pick up these changes in their behaviour.

Sheila : *"Mm, just their persona really. Because you know them well"*

Audrey suggested it was often a friend who recognised a change in behaviour before the individual. In this case the change in behaviour caused by stress was not recognised by the individual until physical symptoms appeared.

Audrey : *"He was drinking too much. Wasn't sleeping at all. He didn't realise it until he started having panic attacks. His heart was beating '90 to the dozen and he was hyperventilating".*

Reference by one respondent was made of an increase in sickness.

Marion : *"She was never ill, then suddenly an odd day here, two days there. We did talk about it, she couldn't face coming to work".*

This statement implies that sickness was due to the psychological effects rather than physical illness. The importance of knowing a person or work colleague well is crucial to recognising some of the more subtle changes in behaviour.

CONCLUSIONS

Findings so far appear to suggest that according to the respondents, the most stressful factor in today's society is work. (See Table 8) When the factors associated with work (Table 9) were explored they appeared to reflect the current pattern of work in the NHS following the reforms, which have resulted in a more business orientation. It was interesting that whilst job insecurity was mentioned the possible financial implications that might entail were not. The feelings associated with job insecurity appears to cause more

stress than the possible associated financial worries? The reasons for this were not clearly evident but it was suggested related to loss of self esteem.

The effects of stress in the main were considered negative, although acknowledgment was made that stress could be a motivator. Both physiological and psychological affects of stress were considered but it was the psychological effects the respondents felt were most debilitating and initially affected work performance. Physical effects of stress generally came later if stress continued unresolved. There was also some suggestion that stress was insidious and cumulative in its effects, perhaps not one event but rather a collection of events over a period of time leading to stress. The effects of this stress were often not recognised at an early stage unless you knew the person well.

It seems reasonable to conclude that stress affects individuals both physically and psychologically and these effects in turn are generally considered to be negative. The most common factor in today's society contributing to stress is work. The aspects of work that cause stress will be considered again in the next chapter, related this time to the personal experiences of work by the respondents. Will there be differences?

PART B The Effects and Management Of a Stressful Life Event

Part 2 of the interview schedule was designed to ascertain how stress affected the respondents. It was anticipated that by asking them to recount a personal experience which they had identified as stressful, may heighten their awareness of the associated feelings and behaviours. This would enable perhaps them to recognise those feeling more readily in the work setting.

Questions one and two in Part 2 of the interview asked the respondents to identify a situation in their personal life that had caused stress, using the check list compiled by Holmes and Rahe 1967 (Appendix 1) Eight respondents readily identified at least one event causing them stress, three respondents identified more than one event. In the latter cases the discussion focused on one of these.

Table 11 identifies the life events that had been stressful for the respondents.

TABLE 11

CAUSES OF PERSONAL STRESS

Sheila	Personal illness/injury, changes at work, changes in sleeping pattern.
Deborah	Death of father
Marion	Personal injury
Elsie	Death of spouse, changes at work, daughter leaving home.
Helen	Death of father
Jean	Unspecified
Beverley	Death of spouse, divorce
Liz	Death of mother
Audrey	Children growing up

(Where more than one event was mentioned, underlining identifies the event described and discussed)

All participants looked at the list compiled by Holmes and Rahe (1967), some looked at all events before identifying one which they wished to describe. Some stopped immediately they encountered the event and then proceeded to

describe the effect it had on them. Only Audrey could not identify an event on the list that caused her feelings of stress. She did give an alternative however. Her concerns mainly centred around the children, both in their early teens.

Audrey : *"I'm quite laid back really. I can see perhaps that one stress is mainly the kids"*

Jean initially did not specify the life event that had caused her stress but during her description of the effect of the event it appeared to have been related to marital difficulties.

Looking at Table 12 there were five main events referred to that caused the respondents feelings of stress :

TABLE 12

1)	Bereavement	(4)
2)	Personal illness/injury	(2)
3)	Marital difficulties	(1)
4)	Children growing up	(1)
5)	Changes at work	(1)

Questions three to six of Part 2 of the interview schedule encouraged the respondents to explore the effects that stress had had on them at the time. The responses fell into three main categories, and concern primarily the psychological effects of stress,

a) the feelings associated with the event;

b) the behaviour associated with the event;

c) the effects on performance at the time of the event;

a) The Feelings Associated With The Event

Table 13 identifies the feelings associated with the effects of stress for the respondents. These have been collected into six sub-categories

TABLE 13

i) Out of Control	(9)
ii) Self Doubt/Lack of Confidence	(7)
iii) Letting Other Down	(6)
iv) Failure	(6)
v) Feelings associated with Bereavement	(6)
vi) Not being Understood	(2)

(The number in brackets refers to number of responses)

One can see from Table (13) that the feeling most commonly generated during a stressful event is that of being out of control. The respondents felt that during the event they had no control over what was happening to them or around them.

Beverly : *"Well, it was totally beyond my control"*

Jean : *"I wanted to get back into control, I think it was just the emotional thing of standing there and just crying".*

Feelings of self doubt/lack of confidence, failure and letting others down due to their emotional state were also referred to by most respondents. Those feelings resulted in an interference in their work performance during the stressful time.

Elsie : *"What I do recollect is the constant worry, had I done the right thing. I couldn't let anyone down by asking to go back"*. [to her previous role]

With the exception of Jean all the respondents felt their lack of confidence and self doubt had affected their work performance. For Jean however, although she felt a failure and lacked self-confidence, work was an escape. When asked if the event had interfered with her performance at work she thought not.

Jean : *"I don't think it affected my performance at work, actually getting the work out and the quality of my work"*.

Her feelings centred around her failure as a person, not as a nurse or manager.

Jean : *"it took away my self-confidence, my self-esteem. I felt totally worthless, I was a non-entity. I couldn't cope with it"*.

Feelings associated with bereavement have been collected together under one category and are compatible with the analysis of the stages of the grieving process proposed by Kubler Ross (1970),

i) Denial, Disbelief

ii) Anger

iii) Bargaining

iv) Depression

v) Acceptance

The respondents concentrated their dialogue mostly around the feelings associated with i) to iii)

Deborah : *"real bitterness and anger. I still couldn't believe, had I taken him back to work he may not have had the episode"*

Helen : *"coming back to work I felt angry, with me for not being there"*

"If I'd not made him go into hospital for that episode ....."

"it was difficult to accept, I hadn't had a chance to, there was no time to be alone with him"

Both Helen and Deborah very clearly express the feelings of denial, anger and bargaining the "what if's" and "if only's".

It is interesting that both Helen and Deborah went into great detail about the loss of their respective parents. For them the discussion heightened the awareness of the event and they talked quite freely of their feelings and behaviour prior to the loss and at the time of the loss. Helen, Deborah and Liz all stopped immediately they encountered the stressful event on the list of life events and began to talk of their feelings at the time. The other respondents had looked at the list in detail before identifying a particular event they could relate with. This leads me to wonder whether or not the three respondents

concerned had some unresolved feelings associated with the bereavement. For Helen that could be expected as her father had died only months earlier. For Deborah and Liz their loss had been many years earlier. All three felt they had gained some relief talking about the event to make sense of their feelings.

Deborah : *"This is the first time I've really talked about how I felt at the time"*

In Table 13 feelings of not being understood were expressed by two of the respondents. This feeling was related to their loss and the belief that no-one could possibly understand how they were feeling at that time.

Helen : *"I felt nobody knew what I was going through"*

As the respondent group included some men I wanted to ascertain if there was a gender issue. Is it more difficult for men to express their feelings related to a stressful life event? The consensus appeared to be that men are not expected to show their feelings and often support is not forthcoming. There are often two reasons for this: either the person offering support does not want to upset the man concerned which may then cause embarrassment, or the man avoids discussing the event because he feels it is not expected. (In the following quote the name has been deliberately left out to protect confidentiality)

"It was actually coming back to face people. I didn't want to talk about it and expose my feelings"

Some of the respondents referred to more than one situation that had caused them stress, however they chose to describe in detail the feelings

associated with only one of those. It transpired however that there were similarities of feelings although the experiences were different.

Deborah recognised similarities between the stress felt at the loss of her father and her divorce of many years earlier. The divorce had not been mentioned as a stressful event until we were exploring feelings associated with her father's loss. During the discussion Deborah became upset and it was then we stopped the tape, when we continued I asked if she could remember any other feelings. I was referring to the time of the loss of her father but had not made that explicit. Deborah referred to the divorce. The issue of divorce up to this point had not been mentioned, indeed I did not know Deborah had been divorced.

Me : *"You've given me some feelings when your Dad died such as anger, the guilt, the 'what ifs', 'if only' any other feeling "*

Deborah : *"Er, yes, the divorce, bitterness, real bitterness because it wasn't my fault. I actually went through, when I look back, a real grieving process of bitterness, anger to indifference and acceptance"*

Me : *"As with your Dad"*

Deborah : *"Well yes, but that still hurts at times"*

Beverly also referred in passing to her divorce but that had been so long ago she couldn't remember the feelings and whether or not they were the same as those when her husband died.

Elsie however did specify that the feelings she had concerning changes at work were different to those experienced with her husband's death and her daughter leaving home after she married.

Elsie : "*When John died it was a different stress*" [relating to bereavement]

Elsie : "*I didn't feel I had enough knowledge and experience to actually take on the job*"

With work Elsie's feelings were more related to lack of confidence.

Whilst different life events were discussed by the respondents, there were similarities with feelings identified, the most notable that of being out of control. (See table 13). However most feelings expressed affected most of the respondents. This leads me to suggest that irrespective of the event causing stress, feelings will be the same.

b) The Behaviours Associated With The Stressful Life Event

All respondents recognised some change in their behaviour at the time of the stressful event.

Jean : "*I was a total bag*

Jean felt at the time she was a very unpleasant person, rude, intolerant of others, wanting others to feel the way she felt. Although Jean recognised her manner towards others changed, she also with the others, identified two main behaviours either avoidance or isolation. However the two seem to complement each other.

Five of the respondents mentioned avoidance as a change in their behaviour at the time of the event. They avoided meeting people to whom they felt they had to talk about the event.

Jean : *"I bottled everything up and unless anyone asked me directly I would lie"*

All five described situations such as this. For some, the recognition of this prompted some action, as a response to the stress.

Two respondents mentioned isolating themselves. Withdrawing into themselves as a means of avoiding the situation, as if it was not happening to them.

Sheila : *"I kept myself to myself and became quite introverted"*

Avoidance or isolation resulted in the same outcome, reluctance to discuss the event causing the stress.

Whilst Elsie had expressed a difference in the feelings associated with her bereavement and the feelings associated with her changes at work, when it came to behaviours there were similarities. In both situations Elsie found herself not sharing it with others, keeping her feelings to herself.

The following quotes relate to Elsie's behaviour, firstly with her changes at work, secondly following her bereavement.

Elsie : *I tried to go through it myself. I didn't really want to talk to people."*

"I wasn't talking to anyone, not even Susan [daughter] because I thought she had enough on her plate"

c) *The Effects On Performance At The Time Of The Event*

The respondents so far had identified the feelings and behaviours associated with the event. Behaviours seemed to be associated with avoiding talking about the situation isolating themselves from people with whom they felt they should or might be expected to talk to about the event. Whether these feelings and behaviours had an effect on their performance is now explored. If stress interferes with performance irrespective of cause as suggested, that has implications for employers as well as the individual.

Questions five and six in Part 2 of the interview were related to work performance. Did the event stop them coming to work or did it interfere with their performance? Other than Sheila and Marion who, due to an injury were excluded from work, all came to work. Those who had been bereaved took the allocated time but no more i.e. 3-5 days. Both Helen and Beverley felt they had returned too soon, but wanted to return to normality as soon as possible.

Beverley : *"After B's death I wanted to come back to work. I think I probably come back sooner than a lot of people do. I felt I actually gave my brain a rest and the normal day gave my brain, well comfort really".*

Seven respondents said the event did affect their performance. One respondent Jean said that it had not, because for her work was a means of escape. For Liz the question was irrelevant, because at the time of her

Mother's death she had not been working, but she did leave school after her Mother died to look after her younger brothers and sisters.

Whilst the psychological effects of stress on work performance are reflected here there are some subtle differences from the opinions expressed previously on the effects of stress on performance generally. For example in the general discussion in Part 1 of the interview, psychological effects on work performance, loss of concentration and interference with thought processes were not linked to work performance (Audrey, infra page 112). However here they are linked. The five respondents that stated stress had interfered with their performance, identified loss of concentration and ineffective thought processes.

Helen : *"I wasn't able to concentrate as normal and often my mind would wander"*

Beverley : *"I felt some of the time I didn't know what was right. I couldn't think clearly at that time".*

The remaining two respondents did not specify how the event had interfered with their work performance, they just acknowledged it had. For Jean, who found work an escape one could argue that her work performance had been affected by the event due to the change in her interpersonal skills (see Jean infra 125).

Management of Stress

It seems that the event concerned did affect the respondents in some way which resulted in a change in behaviour and work performance. What did they do about this? From the literature it appears that individuals respond to stress by initiating some form of coping strategy. In this section of the analysis, the strategies used by the respondents as a response to stress associated with a significant life event were identified and the efficiency of the strategies explored.

Questions, four, seven, eight and nine in Part 2 of the interview were related to how the respondents had coped with the stress. The responses were collected into two categories :

a) effects on behaviour

b) helping strategies employed

Effects On Behaviour

Change in behaviour such as avoidance, isolation and emotional upset have already been referred to as an effect of stress. It is interesting that this behaviour was also seen as a way to manage stress. All nine respondents identified changes in their behaviour at the time of stress. The recognition of this change in behaviour for five of the respondents resulted in them seeking some form of help from elsewhere as a means to reduce the effects of stress both on feelings and behaviour.

Elsie : *"I tried to go through it myself. When I realised I wasn't getting too far I realised I needed someone"*

Jean : *"I knew I couldn't go on behaving like this so I eventually went to a counsellor"*

Recognition of a change in personal behaviour therefore seems significant in that it can initiate some form of response, such as seeking help.

For Audrey, although she did not seek help, she did initiate some action in as much as she recognised her behaviour had changed and looked to her own coping strategies to help resolve the problem.

Audrey : *"I think my background helps in that I recognise the change, the things that are causing the stress and try to do something about it".*

For the remaining three respondents, although they recognised a change in their behaviour it does not appear to have initiated any form of action. Is this due to a lack of knowledge on how to cope in these situations or a feeling we must cope alone?

Helping Strategies Employed

Of the nine respondents five sought help of one sort or another. Audrey said she would have sought help if her own coping strategies had failed. The remaining three respondents did not seek any help at all and tried to work through their feelings alone. It is interesting that two of the three respondents who did not seek help appeared to still have acute feelings associated with the stressful event, despite the length of time since the event. (Deborah and Liz) It seems therefore that if our coping strategies fail or we are over whelmed with

the event it may be useful to seek some form of help at times of stress. However one needs to acknowledge that if one is to initiate this action.

Table 14 demonstrates the sources of help used by the respondents :

TABLE 14

Sources of Help	
Professional Help	(4)
Family/Friend	(2)
None, Self Only	(3)

(The number in brackets donates the number of responses)

Of the six respondents that sought help all said it had been useful and helpful. Three actually sought professional help in form of counselling and stated they had been taught strategies that they could use in other situations at other times. (Elsie, Beaverly and Jean) Three others who used family or friends continue to use that support as it is needed. They do not appear to have developed transferable skills in the same way. The three respondents that struggled alone, still appear to need support and help in times of stress.

It seems that all respondents can recognise when they are experiencing stress by changes they perceive in their feelings and behaviour. Stress in all but one respondent resulted in an interference with performance. It could be argued that all respondents had reduced performance when experiencing stress Jean maintained this not to be the case despite her acknowledgment of her changed interpersonal behaviour at work.

As adults the respondents recognised they needed to resolve those feelings and behaviour. Some did that by coping indirectly through avoidance, not talking about the event, keeping themselves isolated. Whilst

others dealt directly by seeking outside help in the form of counselling to help them through this time. What was not clear from the data is what personal coping strategies they actually employed and where that fits or does not fit with Rice's (1992) model.

Conclusions

It seems apparent from this section that stress can be recognised in an individual and individuals can also recognise stress in themselves. Recognition of this stress should lead to the implementation of coping mechanisms. However individuals need to be encouraged to explore other avenues such as counselling when they realise their own coping mechanisms for dealing with that stress are ineffective. Stress interferes with work performance, therefore, managers and others, who recognise a colleague is experiencing stress, should become pro-active in offering suggestions for help. Those individuals may then feel more able to acknowledge their stress and explore other means for its reduction. Professional help such as counselling appears to equip individuals with transferable skills to differing stressful situations.

CHAPTER 7

Stress At Work

In the previous chapter an attempt was made to explore perceptions of stress by the respondents both in society and personal terms. By doing this it was anticipated that some common understanding could be gained between the researcher and respondents regarding stress. The respondents discussion of a personal life event that was stressful was to heighten their awareness of its effects and enable them to recognise more readily when this had occurred at work. The assumption being made that the effects of stress were the same irrespective of the cause. This chapter explores the concept of stress at work, its causes and effects and not only how the respondents manage that stress but how they see or would like to see the organisation managing stress at work.

Causes Of Work Stress

In Part 3 of the interview questions one and two asked the respondents to identify whether or not it was more stressful for them working in the NHS today than when they first joined and why that might be so. All respondents had worked in the NHS for a minimum of 18 years.

Seven respondents stated that it was now more stressful. One respondent wasn't sure, but felt stress was acknowledged more nowadays and the other respondent stated it was different for them now, due to increased responsibility and knowledge suggesting it was that increased responsibility that could be stressful.

Audrey : *"It's different. As you go through the organisation you seem to get more responsibility. When I was a young student nurse I had not a care in the world. As you get older you start seeing the pitfalls and the things that could go wrong".*

The examples that were given as to why working in the NHS was more stressful, seemed to relate to organisational factors. These areas were very similar to those areas identified in Part 1 of the interview concerning stress in today's society (Table 9). Table 15 identifies the factors that the respondents considered contribute to stress at work for them. If we compare this data and the data in Table 9 there are similarities.

TABLE 15

	Factors Causing Stress At Work	
i)	Change	(5)
ii)	Competitiveness	(3)
iii)	Financial Constraints	(3)
iv)	Faster patient turnover (patient, the product in this case)	(3)
v)	Lack of preparation for the changing role of nurse manager	(3)
vi)	Position/Role in the organisation	(2)
vii)	Job insecurity	(2)
viii)	Time limits	(2)
ix)	Personalities	(2)
x)	Woman's' role at work	(1)

(The number of references to each item is in brackets)

As with the perceptions of work related stress in society, points ii, iii, iv, vii and viii can all be linked with change and the business orientation of the current NHS. Change itself was referred to by 5 respondents as being stressful and related to the changing management system.

Liz : *Change again. The purchaser/provider and competitive nature now.*

Beverely : *Its only because we've been constantly in change and transition for what seems like forever, but more acutely this last few years.*

Points v and vi refer to the changing role of nurse manager in that system. In Chapter 3 the role of the nurse manager was explored and it was suggested it has changed significantly with the NHS reforms, from one where he/she was only concerned with the management of nursing and direct clinical care. The main responsibility being to ensure sufficient nursing staff were available to deliver care to patients. Now these nurse managers are expected to be managers of the total resource. They are involved in resource allocation for the whole division which may be composed of disciplines other than nursing and are expected to assist in the balancing of the budget. No longer can they call in a bank nurse to help out in times of sickness, without justifying that need and finding the money. Cooper et al (1988), suggests that if the role an individual holds in an organisation concerns responsibility for people along with budgets and equipment this can create stress or increase stress. This notion appears to be supported by the respondents, whose role involves these responsibilities.

Audrey *"... balancing operational requirements with responsibilities and managing the resource within financial constraints*

The respondents also perceived lack of preparation for this changing role as stressful. The middle manager today must be aware of the competitive nature of the Trust and the need to gain and maintain contracts with the purchaser. This is very different from the past when patients were automatically admitted to the hospital in their locality. Now with GP fund holders, patient choice and purchaser contracts, this is no longer the case. For a Trust to survive they must offer what the purchaser and consumer wants otherwise the purchaser will go elsewhere.

Marion *At times I feel I don't know what I'm doing, especially when we're working on contracts. It seemed so much easier before.*

The other factors identified by the respondents were personalities and woman's role at work. Personalities working in the organisation can create feelings of stress for those working with them. Both Elsie and Helen mentioned this factor and it generally concerned staff working in critical care departments rather than hospital wards.

Elsie *She came into coroney care with a coroney care course but wasn't up to date. She needed support, obviously with hindsight she didn't get the support.*

From personal experience I know that staff within these areas have often worked there a long period of time and are very experienced. Staff joining that team sometimes have difficulty in becoming an accepted member.

Why this is so is difficult to establish. It does not seem to be the same for new members of staff joining an established group working in a ward area.

Critical care areas appear to have some characters whose personality controls the behaviour of the others. New members to that group, be they student nurses or qualified staff, who do not conform to the expected patterns of behaviour are made to feel outcasts and of no worth. Student nurses going to these areas are often concerned, not of the work they may encounter but of the staff personalities they will meet. (Birch 1975, Fretwell 1985)

One cannot generalise that all critical care areas within the NHS have the same problem. However anecdotal and observational evidence would suggest this is the case in some units. Elsie actually called it "bullying" in relation to a critical care area which she was associated with.

Elsie *"It isn't the first time we've gone through situations like this in the area, I would say its bullying"*

A bully according to the Oxford Wordfinder is "a person who uses strength or power to coerce by fear" (Oxford Wordfinder 1993). Elsie went on to discuss the issue of bullying and how it is often not recognised as such by the recipient. Staff are often reluctant to complain about the individuals concerned so little is able to be done to correct the problem.

Helen also refers to the personalities she encountered when first joining a critical care area.

Helen :*"I went away from the interview and said to people I've been offered the job, then I started to hear the bad things and perhaps of one person in particular and I thought 'God have I done the right thing'*

The department was very stressful because of the personalities, the very strong personalities."

Helen survived her experience, she believes, because she herself had a strong personality and would stand up to the others. It also helped that she was the same grade as the other "power holders". Helen goes on to suggest that strong characters are needed in these areas due to the rapidly changing situation and emergencies that can occur. However if these characters behave in such a way that staff leave the area of work and or suffer illness, the managers must take this issue on board and address it.

Audrey mentioned the issue of women at work and their many roles. Audrey felt that women although encouraged to continue with their careers whilst managing a family, did not receive the support in the form of flexibility from their managers. To ensure women are able to pursue a career and have a family requires not only a change in society's expectations but also a change in the organisation's expectations. Women are still seen as the major carer in the home. If the NHS wishes to look after its workforce, who are predominately women, then it needs to encourage more flexible working practices to allow women to do this.

Audrey :"*I see especially some of these younger women really having to combine these two things and really having difficulty doing it*"

This balancing of roles can become more problematic now due to job insecurity and the fact these women are often the major wage earner in the family. The possibility of losing their employment aggravates the already stressful position in which they find themselves in.

Questions three and four in Part 3 of the interview asked the respondents to personalise what it was about their work that caused them stress. Six respondents were requested to keep a journal, recording the stressful work event as soon as possible after it happened and it effects on them. Sheila, Audrey, Beverley and Liz all referred to their journals to identify these events and effects. Marion and Helen both stated all days were equally stressful and no-one day was any worse than another and had not recorded them in a journal. However despite the lack of recording they both were able to identify specific work situations that caused them feelings of stress and why this was so.

Situations that appeared to create feelings of stress for the respondents centred around the conflict they felt between their nursing and managerial role. Incidents such as disciplinary matters and giving the results of managerial profiles which they knew were going to be unpopular with the staff were identified. Table 16 gives an overview of the situations that gave the respondents feelings of stress at work.:

TABLE 16 :

	Specific Work Situations Causing Stress	
i)	Increased work due to sickness/holiday	(5)
ii)	Behind with work timetable	(5)
iii)	Sorting out problems of others	(4)
iv)	Outcome of management profiles	(3)
v)	Disciplinary matters	(2)
vi)	Clinical grading appeals	(2)

(The number of references to each item is in brackets)

Increased work load due to holiday/sickness of self and/or others (but usually others), and being behind with work timetables could be seen to be

connected. There appears to be no provision made for a deputy to carry on the manager's work when they are sick or on holiday. This particular group however had minimum sickness, only one had been sick during the last year.

> Elsie *"Amount of work and timing of work. For instance if you have a weeks holiday no-one does your work. You come back on Monday and you've got to have things done for Tuesday because it's been there all week"*

If an issue is so important that a deadline is necessary then provision should be made for someone else to provide the information if the usual person is unavailable. If they are the only person with that ability and knowledge, then that must be taken into consideration when specifying a completion date.

With regards to being behind with work timetables, sickness or holiday was not always the reason. There seems to be a huge volume of work in the form of statistics and other data collection in the current NHS. The time schedules for producing this data is very short. This results in the respondents working excess hours or taking work home to ensure it is completed by the given date, increasing their work load. Work overload has been identified in Chapter 2 as a factor associated with stress at work and the literature reviewed in relation to the NHS supports that notion, as do the respondents.

Sorting out the problems of others was a specific situation that caused stress to the respondents as it indirectly increased their own workload. This was particularly frustrating when the respondents believed the staff had the appropriate skills to sort their own problems.

Jean : *"They'll ring you and say 'I've got a problem, but if you talk it through with them they'll actually solve their own problem but it's taken 20 minutes of your time and you think they could have done it, all they needed was a push"*

Outcome of management profiles, disciplinary matters and clinical grading were the remaining specific situations that caused the respondents stress. These situations can be seen as a composite part of the manager's role or position in the organisation. For some reason respondents found these aspects of the role particularly stressful. Most of the causes of stress for the respondents appear to be related to their management role in the NHS.

Conclusions

It seems that working today in the NHS is more stressful for the respondents than when they first joined. Acknowledgment is made that this increase in stress is in part due to their more senior role. Table 15 suggests that some of this stress can also be attributed to the organisational changes leading to the more business orientation. As Cooper et al (1988) proposes, the role one has in an organisation can be stressful but for the nurse in middle management this can be particularly so due to their changing and evolving role from nurse manager to general manager. The resultant increase in workload and lack of preparation for that role also appear significant.

The remaining two factors associated with stress at work were not directly associated with the respondents but do need consideration by the organisation, that of personalities and or bullying and women's role in society. Bullying can occur in any organisation where individuals are identified as "different". Women's role in society and in the world of work can be transferred to any organisation. However as the Region initially appeared to support Opportunity

2000 it is disappointing that this local Trust does not appear to be making it easier for women to return or stay at work by designing more flexible working practices and better child care facilities.

When one compares the organisational factors the respondents identified as causing stress at work with those that were specific to them, most concerned their role in the organisation. However the situations they identified, it could be argued are a integral part of a managers role. The problem this poses therefore, seems to concern whether the stress experienced by the respondents, is due to lack of preparation for that role, or, that the stress encountered in this role is inevitable and thus the respondents need preparation to handle stress more effectively. It is not clear from the data which it may be but does require further exploration. What is clear to cause stress however is the apparent increase in workload within their role and the associated time scales brought about following the NHS reforms.

The Effects Of Work Stress

Earlier in the work the effects of stress related to a life event were explored. Are these effects the same or different when associated with stress at work? All respondents could recognise the effects of stress at work for them. These effects fell into the two categories, physical and psychological and reflect the effects of stress described at the beginning of the analysis (see page ?). As then, the physiological effects of stress were deemed less debilitating and evident than the psychological effects of stress.

Table 17 gives an overview of the physiological effects of work stress experienced by some of the respondents. Not all identified physiological effects of stress.

TABLE 17

Physiological Effects of Work Stress		
i)	Sleep Disturbances	(4)
ii)	Palpitations, Agitation (Adrenaline Release)	(3)

(The number of references to each item is in brackets)

Sheila did suggest that stress may have been a contributory factor for her contacting a "tummy bug" Selye's (1978) work related to stress interfering with the immune response would support this idea.

Sheila : *"I actually had D and V [diarrhoea and vomiting] and I'm sure it was because of the stress, that my resistance was low, I was tired, that I picked up the bug"*

The psychological affects of work stress reflect those referred to earlier associated with of a personal life event and encompass also,

i) the feelings associated with work stress;

ii) the behaviour associated with work stress;

iii) work stress and performance;

i) The Feelings Associated With Work Stress

There were some similarities with the feelings experienced during stress associated with a personal life event and feelings associated with stress at work.

TABLE 18

Feelings Related to Work Stress	
a) Out of Control	(8)
b) Self Doubt/Lack of Confidence	(8)
c) Being misunderstood	(5)

(The reference to each item is in brackets)

Out Of Control

This was mentioned by eight of the respondents. They reported feelings of being overwhelmed by the amount of work expected of them in a very short time span and not being able to see a way of completing the work. As with the experience of stress in the life event, the respondents did not seem to be able to organise what they needed to do. The situation was too intense.

Marion :"*I just get to the point where I feel totally overwhelmed. Don't know which way to go next*".

Another issue that gave the respondents feelings of being out of control related to their role in the organisation and could explain why the outcomes of management profiles, disciplinary matters and clinical grading caused them stress. They often felt conflict between their management role and their nursing role. They did not want to be seen as "underselling" nursing but also had a need to be loyal to the organisation.

Audrey *"Something that's given me concern is actually having to implement the results of a re-profiling exercise. Now I don't particularly agree with the results and have said so but I can't share that with the staff"*

Similar feelings were expressed by a further five of the respondents. Deborah and Liz mentioned they felt squeezed between grass-roots and senior managers, unable to quantify their worth. They felt their opinion was not valued by either side and thus they felt unable to influence the decision making process.

Deborah *"I think at our level we are caught between two stones because I very much know [sic] what staff are saying to me and I can also see the other side of the coin and yet am not able to get other parties to see that"*

The feeling of being unable to influence discussions within an organisation has been suggested by Cooper et al (1988), as a stress creating factor in the work setting. Being in a recognised position of influence within the organisation and yet feeling unable to influence the decision making process is a stressful situation for these managers, aggravating their feelings of being out of control.

Self Doubt/Lack Of Confidence

All eight respondents who mentioned feelings of being out of control also mentioned that this led to feelings of self doubt about their professional ability. Subsequently they then began to question their work performance. The expectation that they should complete a task in a given time made them feel inadequate if they could not do that.

Elsie *"I felt I didn't have enough knowledge and experience to actually take on the job"*

Helen *"I think I'm the only one who doesn't know what they are doing"*

Lack of peer support and sharing between managers in this situation appeared to aggravate the feelings of self doubt. Liz felt there was less sharing of problems and less peer support than in the earlier part of her career. The sharing and peer support enabled staff to feel they were not alone. If Helen had been able to share her feelings of being out of her depth with her colleagues, she may have found others felt the same.

Liz *"I don't think there is the camaraderie that there used to be. You worked hard but it didn't alter the fact you could have a laugh together and share problems"*

Liz went on to suggest that this lack of sharing was aggravated by the competitive nature of the organisation.

Liz *"I think more people are so involved in looking to their job they won't share in case its used against them"*

Being Misunderstood

A feeling of being misunderstood about their role in the organisation was mentioned by five respondents. Friends and family who do not work within the NHS it was felt, could not appreciate the demands it makes of its employees, in this case managers.

Sheila :*"I think it is difficult for friends outside the NHS to appreciate what we are trying to come to terms with. They can't accept because a colleague's husband died I had to step in, they say you shouldn't have to do that".*

Whether or not the organisation expected Sheila to stand in or not is difficult to ascertain. What is clear is that Sheila believed she had to stand in for her colleague. As far as she was concerned in this situation she was the only one able to do that. The fact it meant she worked almost a 24 hour day did not enter into it. One needs to question therefore, whether the organisation was aware of that fact. If it was and condoned it or accepted it, what value is placed on employees when they are expected to work through the 24 hours? If the organisation was unaware but Sheila presumed this was expected of her, from where does she obtain these messages?

Similarly managers felt their subordinates, because they did not understand the manager's role, under-valued it. Value within nursing appears to be given to those who deliver "hands-on" care. The manager who facilitates that process does not appear to be valued in the nursing culture. This can lead to feelings of isolation aggravated by the apparent lack of sharing among managers.

Helen *"They don't have a perception of what our job is about"*

Cooper et al (1988), when discussing relationships at work refers to this. Managers who traditionally are seen as distant and autocratic may end up feeling a sense of isolation and "not belonging". This suggested an educational issue. The organisation perhaps needs to consider awareness sessions for staff of the various roles within the organisation. This maybe one method of introducing the idea that all who work within the organisation have

an equally important part to play in its effective function, a form of team building.

ii) Behaviours Associated with Work Stress

Behaviours associated with the psychological effects of stress do differ slightly to those mentioned related to the personal events. Rather than avoiding the event, or isolating themselves from it, at work the respondents confront the problem causing them stress. All nine mentioned they tended to keep mulling the event problem, over in their mind until they found a solution or course of action. Five respondents mentioned a change in their emotional behaviour. Deborah stated at times of stress she became more "weepy" whilst the remaining four were less tolerant with others and more liable to become angry.

iii) Work Stress and Performance

Although not explicitly mentioned by the respondents, the impression was given that their feelings and behaviours associated with the stressful event interfered with their performance. If they were not in control of either the work or their feelings then their professional ability was in question.

> Helen ;"*I hate to feel irritated or out of control How can I function with those feelings?*"

Similarly if the individual is tired because the stress is interfering with their sleep pattern then that in itself could interfere with work performance.

> Marion :"*When I don't sleep I feel dreadful. This bothers me more because I know I won't be able to think clearly at work tomorrow*"

Conclusions

The effects of stress at work appear to affect the respondents in a similar manner as the effects related to a personal stress event. Whilst both physiological and psychological affects were identified, it seems the psychological affects of stress are most debilitating and are more likely to interfere with work performance. The feelings and behavious associated with this cause of stress, whilst reflecting those mentioned in the previous chapter, now seem more related to feeling out of control in the work setting, resulting in a lack of confidence, drop in self-esteem and a change in their emotional behaviour. These feelings and behaviours if not controlled or managed, can interfere with their performance at work. It now seems reasonable to accept that stress, irrespective of cause can interfere with work performance.

MANAGEMENT OF STRESS

The Strategies associated with managing stress at work were collected in two areas. Personal management of stress and Organisational management of stress at work.

a) Personal Management of Work Stress

Recognition of stress at work does not appear to have prompted the respondents to seek help to the same extent or in the same way as many did when stress concerned a personal issue. However, they all made some changes in behaviour or took some action as a means to reduce the feelings of stress they experienced. Table 19 identifies their course of action.

TABLE 19

	Personal Management of Stress At Work	
i)	Take it home, discuss with spouse	(4)
ii)	Prioritise	(3)
iii)	Discuss with Colleague's)	(3)
iv)	Eat, Drink more	(3)
v)	Say No (Assertive)	(3)
vi)	Use Relaxation	(1)
vii)	Talk To Line Manager	(1)

(The reference to each item is in brackets)

Four respondents take the situation home and talk it through with their spouse or mull it over whilst doing other things. However, they did recognise that although this allowed them to "sound off" it often didn't help resolve the situation. For some however, mulling it over at home enabled them to obtain some focus as to what was causing the problem and to plan some course of action to resolve it.

Deborah : *"I take it home, not intentionally, but I find myself thinking about things if I've got a problem when I get home".*

At this point Deborah became upset again, but did wish to continue. She believed she still felt quite vulnerable emotionally because we had been talking about the loss of her father and an event that had occurred during her holiday which had left her still feeling "shaky". Deborah felt that due to that incident she had not been able to fully "re-charge her batteries" during her holiday and instead of returning refreshed she felt just as tired and stressed as before the holiday, despite the fact she had tried to leave work behind.

Deborah *"I think its because I was stressed before the holiday that the particular event during my holiday affected me so much. I did try to dump it [stress] to the back end of the week before the holiday".*

It would appear that although Deborah had some mechanism or strategy she used to enable her to try and leave behind the work stress, it had not been effective.

Prioritising the work was a strategy used by only three of the respondents. This is a useful strategy to be employed in any situation when the amount of work to be done exceeds the resources available. What is it that apparently stops these experienced nurses using this strategy when in the clinical setting they were prioritising all the time? Is this another educational aspect to be considered for preparing staff for this management role?

Sheila states she has become quite ruthless when prioritising her order of work.

Sheila : *"I've become a bit lethal these days and if I don't know what to do with a bit of paper and the time scale has gone and no-one has asked, I put it in the bin".*

Sheila goes on to say that it is quite an achievement for her. This behaviour, which has developed over the past few years, enables her to keep the level of work manageable.

Three respondents discuss the event or problem causing them stress at work with a colleague or colleagues. This can be useful on two counts. Firstly

colleagues understand the extent of the problem and secondly it is a means of sharing that problem. This notion of sharing has been referred to in the literature review as an effective stress reducer (Rice 1992). Peer support has already been mentioned in an earlier part of the analysis as lacking in the work setting, leading to feelings of isolation. As peer support is mentioned by one third of the respondents as a stress reducer it warrants consideration and needs to be encouraged.

Three respondents referred to eating and drinking more as a response to stress. These behaviours they recognised as being related to stress. Measures such as these have been referred to as "palliative coping" (Meichembaum and Calman 1983) and are a method of indirect action to cope with stressful events.

Factors v and vi were strategies used by the respondents who had sought professional help during their stressful life event. The skills of assertion and relaxation were skills they now used in the work setting as measures to reduce stress.

Beverley : *I sort out priorities and I do tell people when I can't take things on.*

Jean : *.... if I've got something I'm thinking on ... then I'll probably go to the gym. Then maybe an hour or so I'll feel fine. I wouldn't dream of taking it home with me.*

It is interesting that although some respondents report to the same line manager not all will discuss feelings of stress with that line manager. The respondents reported to four different line managers. The following table demonstrates who reports to whom.

TABLE 20

	Manager 1	Manager 2	Manager 3	Manager 4
Sheila	X			
Deborah		X		
Audrey		X		
Marion			X	
Elsie				X
Helen			X	
Jean				X
Beverley				X
Liz				X

Sheila was the only person that reported to Manager 1. She would discuss feelings of stress irrespective of cause with that person because she believed they had a mutual respect and trust for each other. They had also worked together for a considerable length of time which had assisted in the development of their working relationship which included confidentiality.

Deborah and Audrey both reported to the same line manager (Manager 2). Audrey would discuss stress related to personal issues only with the line manager, Deborah would not. Deborah did not have that trust in the line manager and did not want to be seen as weak by admitting to stress irrespective of cause and discussed the differing management styles of previous managers. She had felt 'safe' with one manager who had been quite directive in her style.

Deborah : *"She would call a meeting, 'Have you got 10 minutes, I'll see you in the office and she told you what to do. You went away and you knew where you were working, she'd given you a job to do".*

Manager 2 is relatively new to both Deborah and Audrey. The new management style was different, less directive and expected professional opinions from them as a means to aid the decision making process. This manager is not a nurse, however recognises the need to take advice from appropriate expertise. I also explored the gender issue. This manager was male and previous managers had been female. Neither respondent felt that gender was an issue, but rather the personality and management style. However, Sheila was supporting a colleague who did report to a man and could not talk of difficulties with him, as he quite openly expressed the belief that women were weak.

Marion and Helen also reported to the same manager (Manager 3). Neither would discuss feelings of stress with their manager unless.

Helen : *"I'd reached breaking point".*

The reasons they gave echoed those of Deborah. They would not discuss feelings of stress, particularly related to work as they did not want to be seen as unable to cope.

Elsie, Jean, Beverley and Liz all reported to the same line manager (Manager 4) and had all worked with that line manager for the same length of time. Jean would not discuss feelings of stress with her line manager, she would have in the past but not now. Obviously somehow their relationship had changed, Jean went on to say,

Jean : *"Its the person, I probably would have done beforehand, but not now"*

Jean went on to imply that she no longer trusted the manager's confidentiality and doubted his/her honesty based on past experience.

Trust, confidentiality and acknowledgment that feelings of stress are not a weakness, seem to be the qualities required of managers within the organisation if staff are to discuss those feelings. For this to happen the organisation needs to foster and develop those qualities in its workforce, particularly of managers.

b) Organisational Management of Work Stress

Eight of the respondents did not believe the organisation recognised or acknowledged stress in its workforce, although two felt some "lip service" was made towards it. Deborah was not sure, and felt it depended upon the individual manager, suggesting that the organisation as a whole did not. For an organisation to take this issue on board requires a certain culture which all managers would need to accept. The following account is how the respondents would like to see the organisation respond to employees who may encounter stress in the work environment. The responses fell into two areas, responses related to the culture of the organisation and actual strategies that could be employed by the organisation as a response to stress at work.

Table 21 gives an overview of the cultural issues the organisation should consider.

TABLE 21

Cultural Issues		
i)	Acknowledge that stress at work exists	(8)
ii)	Acknowledgment that stress is not a weakness	(8)
iii)	Demonstration of openness and honesty	(5)
iv)	People need to feel supported	(3)
v)	Do not penalise stress	(1)
vi)	Listen without judging	(1)

(Brackets denotes number of responses)

Statements (i) and (ii) were linked. Each time a respondent referred to the organisation recognising stress, they also stated that for the organisation to do that, employees must speak out. However, employees would not speak out whilst they believed they would be seen as weak or unable to cope.

Helen : *"I still believe that if you acknowledge stress then you are acknowledging a weakness. I think people see it as a failing, not able to cope and that's all linked with self esteem".*

As the respondents included two men I wanted to explore if this acknowledgment of stress was the same for both men and women.

Helen : *"I think its worse for men than women. They don't want to show their vulnerability, weakness. Its not expected a man would show he was upset about something".*

Although there are fewer men in nursing than women, proportionally they hold the more senior positions. (Tate 1996) It is reasonable to assume

therefore that the acknowledgment of stress for this group of nurses is exacerbated by the gender issue. If it is a weakness to admit to stress within the NHS it must be almost impossible for a man, working as a nurse and manager in the NHS to feel secure enough in himself to admit to feelings of stress at work. As was shown earlier in the analysis, stress in a man's personal life is also difficult to admit in our society.

Five of the respondents referred to openness and trust on behalf of the organisation. This was mainly related to management decisions. There appeared to be an impression amongst the managers that after results of management profiles and exercises, the results and options for responding were not discussed openly with employees, especially if they had shown an increased resource need, i.e. for staff increases. A certain amount of information was withheld and a true picture not often given.

Elsie : "*We actually got a commitment from the meeting before the results were out that they would respond irrespective of the outcome, but they are obviously kicking their heels. We're actually saying that we have proved we are recording dangerous levels of care, what are they going to do about it?*"

People need to feel supported working in the organisation. They need to feel secure. If they are working in an environment where they believe that information is kept from them then it is understandable employees will distrust the organisation.

Statements (v) and (vi) concerning penalising stress and listening without judging could be linked with statements (i) and (ii) . If employees feel that the organisation sees stress as a weakness and staff expressing those feelings as being unable to cope, then judgments are being made. Similarly, if

a person wants to gain promotion in the organisation then they will not admit to stress as it could jeopardise their promotional prospects. They are therefore penalised.

Sheila : *"I think people who have done it [expressed feelings of stress] have been penalised and that makes the rest of the organisation unable to do so".*

Having addressed some of the cultural issues for the organisation the respondents then went onto describe strategies that could be employed by the organisation as a means to manage stress in its workforce. The implementation of such strategies however needs to be accepted as necessary by the organisation and given some value and importance. A cultural change as suggested by the statements in Table 21 entails a change in the values, beliefs and behaviour of the organisation. This must come from the senior managers and be demonstrated in their behaviour and the support that is offers to employees.

Table 22 gives an overview of suggested helping strategies :

TABLE 22

	Proposed Organisational Strategies As A Means To Manage Stress At Work	
i)	Training for role	(5)
ii)	Feedback on work performance	(3)
iii)	Stress management courses	(3)
iv)	Effective Sickness monitoring	(2)
v)	Counsellor	(2)
vi)	Reward	(1)

The most important strategy identified by the respondents is preparation for role in the form of training. This links with what was found earlier in the study. The roles of personnel within the NHS are changing. No longer can staff rely on their clinical expertise alone in their management role. Effective in-service and post qualification education is crucial to ensure staff have the confidence and role clarity to function efficiently in the changing health service. Feeling in control of their working life by being prepared for that role will reduce feelings of stress.

Feedback on performance was also seen as important to the respondents, to know if they are performing to expected standards. It also allows for identification of training or educational needs. This feedback needs to be constructive, not just critical and the use of Individual Performance Review is one method that could be employed. It is designed to recognise individual staff needs. Reward for staff also links in with feedback on performance. Reward does not necessarily relate to monetary reward. Being told that one is doing a "good job" even occasionally gives an individual a feeling of self worth and of an important part to play in the organisation.

The running of stress management courses by the organisation was seen as a means of helping staff cope with stress. It was stated that these sessions could include courses on assertiveness training, development of coping skills and debriefing after stressful events. The strategies identified have already been mentioned in Chapter 4 following the literature review. By offering stress management courses the organisation is acknowledging the existence of stress. By utilising stress management skills an individual is able to channel stress more constructively thus reducing its possible harmful effects.

Although not directly seen as a stress management course, Helen suggested the use of leisure facilities should be made available. It is interesting

that in the past hospitals often had their own leisure facilities in the form of tennis courts, badminton courts etc. These facilities have disappeared from a number of acute hospital sites. The reasons for this seem to centre around declining use. Could it be due to the fact that there is less camaraderie, less peer support and sharing than in the past. There are less staff living in hospital based accommodation as this is no longer a requirement for student nurses or trained staff. In the past senior nurses, mostly women, were unmarried, lived in hospital accommodation and used such facilities. With the changing role of women, these senior nurses are now often married with children and live away from their place of work. Facilities for recreation on site therefore are becoming less necessary. Similarly, as nurse education moves to Higher Education, student nurses can utilise University facilities for recreation.

Effective sickness monitoring was mentioned by two respondents. Monitoring of sickness in this sense is seen as a supportive way of identifying staff who need help. Occupational Health Departments have often been seen as somewhere an employee is sent as a form of discipline if they have excessive sickness. The respondents suggest this should not be the case. All staff should be seen on return to duty after a period of sickness and referred to Occupational Health as necessary. This would enable the manger to detect any possible problems before they arise and offer help. Flexibility of working may be all that is required to help someone through a difficult time. That in itself could keep someone at work rather than them reporting sick.

Jean : *"Tighten up on sickness and see staff when they come back. Quite useful, malingerers don't like it. Managers need to be careful they don't go over the top and frighten people, but the money saved can be used to give those people who need it extended leave".*

Jean is suggesting here that this monitoring must not be seen as punitive otherwise it will defeat the objective. Managers must handle this monitoring carefully and ensure that those who need help and support are given that help and support. Those who may manipulate the system maybe less likely to do so if this process was followed.

Access to a Counsellor was mentioned by two of the respondents. However, all respondents were asked if they thought a Counselling Service would help. Three respondents said yes, five respondents stated a counselling service might help and one respondent said it would not help, it had been tried before and staff did not use it.

Elsie : "..... *one death after another. We arranged for someone and told staff a confidential service was available. Nobody went. The said they could cope*".

Elsie goes on to say that she did not feel they did cope but couldn't force them to use the service. Elsie speculated as to why the service was not used and some of her reservations were echoed by those who also had doubts. Mainly it was felt that the culture of the organisation did not support this strategy. For staff to utilise a service they had to admit to feelings of stress and at this moment in time stress is still seen as a weakness.

For a counselling service to succeed, the respondents suggested the personal qualities of the counsellor were important. That person needed to be trusted by staff and have some awareness and understanding of the organisation. Office accommodation needed to be remote from the organisation. This detracts from the notion that it is acceptable to use such a facility by hiding the counsellor away, so individuals are not seen going into

the office. Confidentiality was crucial, supporting the suggestion of Milton (1993), of factors to be considered when establishing a counselling service.

When the respondents were asked if they would use a Counselling Service the responses were mixed :

Yes - 1 respondent

No - 3 respondents

Possibly - 5 respondents

Again the main reasons given for reluctance to use the service concerned the culture and confidentiality. Until stress is acknowledged by the organisation and not seen as a weakness then staff will continue to suffer in silence.

Conclusions

When managing stress at work the respondents appear to use their coping skills, similar to those used to manage a stressful life event. What is different is that those who had used a counselling service during personal stress with the exception of one, would not use that service for work stress. There appears to be two main reasons for this. It could be they find the skills developed from the past involvement with such a service are adequate to help them cope with stress at work. It could also be however that they find it difficult to admit to feelings of stress at work and do not want to be seen as unable to cope. Somehow it seems more legitimate to admit to stress related to a personal issue than a work issue. This is reflected by the number of respondents who would not discuss work stress with their managers. For the organisation to manage effectively stress in the workforce necessitates an acknowledgment

that stress exists. Once this has been achieved then strategies such as those mentioned in the literature and by the respondents can be employed. However whilst the respondents could see the benefits of a Counselling Service, it seems this service would only be of use if seen as one strategy of many. However even with that scenario it is unlikely that until the "culture" changes, in as much stress is no longer seen as a weakness, the service would most likely be under utilised.

CHAPTER 8

Conclusions

This final chapter will consider the content of the the thesis and offer overall conclusions based on that content and also reflect on the process by which the data was collected. The study was undertaken as a means to explore the contribution of a counselling service in the reduction of stress in the NHS. As the NHS is a large employer, with a huge number and variety of staff, the study focused on one group; nurses working in a middle management role and the questions formulated were examined in that context. The questions were :

1. What are the factors causing stress at work for nurses working in the NHS, particularly nurses in a middle management role?
2. How far is stress aggravated by the organisational structure of the NHS and the recent reforms?
3. How far and in what ways can the NHS as an organisation attempt to reduce stress for its employees?
4. Does a counselling service have an important role in such a strategy?

The questions were examined through consideration and exmploration of secondary sources and directly through a small qualitative study which enabled some primary data to be collected. The secondary sources established a widely shared opinion that demonstarted existance of stress associated with nursing and its effect on performance. Not only is stress associated with the intrinsic nature of the job, direct client care (Cooper at al 1988), but also

associated with the other factors proposed by Cooper et al (1988), concerning relationships at work, career development, role in the organisation and organisational structure and climate. However, not all these factors were clearly related in the literature to nurses working in a middle management role. These sources also suggested some aspects of the NHS reforms could reduce stress, such as the flatter organisational structure which was created. However, other aspects of the reforms could create stress. One example, was the role of the nurse in middle management and how this has changed dramatically since the reforms. This aspect deserved further consideration.

Strategies were identified from the literature that employers could utilise as a means to reduce stress for its employees and included the role a counselling service may play. However, there appears to be a reluctance on behalf of nurses to admit to feelings of stress to the organisation. The reasons for this were not clear from the literature. The reasons as to why the organisation should initiate strategies to reduce stress for employees were examined. The issue of cost effectiveness of the programmes was considered, as no matter which strategy was employed, there would be a cost to the organisation. These costs primarily concerned the training of staff in "running" or managing those strategies and secondly the "time out" for employees. The cost however was out-weighed by the benefits of reduced sickness/absence rates and improved performance by those organisations which had implemented such strategies.

It seemed from the secondary data therefore that strategies could be employed by the NHS which would reduce stress for employees and a counselling service did have a role to play in stress reduction. However these conclusions were based on generalisations and did not readily relate to the target group. For that reason those opinions were tested by collecting data from the target group through the following questions :

1. What are the factors at work that cause stress for them?
2. How are they affected by stress, be it personal or related to work?
3. How did they manage stress?
4. How would the respondents like to see the organisation manage stress in the workforce?

Following analysis, the data obtained from the respondents was organised under three key areas : their general perceptions as to the causes and effects of stress, the effects and management of stress associated with a personal life event and the causes, effects and management of stress associated with an impact on work.

It can be seen from the analysis that there was some common understanding among the respondents as to the general causes and effects of stress in society, as well as the term "stress". All considered stress to be the result from external influences which could affect an individual physically, psychologically or both. However they believed the psychological effects of stress to be the most debilitating. Whilst acknowledging some stress was necessary to motivate individuals, it appears that when they considered stress,

they tended to consider the negative effects rather than the positive. Thus, when asked if they could recognise stress in others they described the negative effects of stress in the individual not the positive effects. Stress therefore for them was a negative concept.

When the respondents were asked about stress in today's society, work was mentioned by all. The reasons for this included increased expectations of people, job insecurity, competitiveness, business orientation and change. A comparison between the respondents views about the sources of stress in society and within organisational settings was undertaken, there were notable similarities. There were also notable discrepancies. Change is the factor most frequently cited as causing stress. Change is related to the functioning of the NHS as a business, hence competitiveness and financial constraints are mentioned and change is also associated with their changing role. It seems, therefore, that there is a deficit in the organisational management of change.

During exploration of the secondary sources it was difficult to apply all the factors associated with the causes of stress at work suggested by Cooper et al (1988) to those nurses working in a middle management role. However when the data from the respondents were examined there were some common areas. They were primarily work overload, role in the organisation, relationships at work and organisational structure and climate.

Work overload in this context was mainly associated with the lack of deputies to cover their work when they were on holiday or were sick and the

frequently short timetable for producing work. This resulted in having to work extra hours to complete the tasks in hand. This would suggest that some organisational changes are required, e.g. adequate deputising arrangements during holidays and sickness and more long-term planning of work would help to lessen the stress. The requirements of the organisation related to budgets and the more rapid patient turnover appear to also have increased. This, coupled with short deadlines, increases the workload for the nurse in a middle management role, a workload which only she/he alone at the moment can complete. Deputising arrangements would not only reduce the increased workload experienced on return from holiday and/or sickness, but would assist in the preparation of future middle managers and give assistance during short deadlines.

The role of the nurse in middle management has changed since the implementation of the NHS reforms. This was identified in the secondary data and reinforced by the respondents. Their responsibility is now as a manager of the total health care resource and no longer concerns only the management of nursing personnel. Their stress in this role appeared to be increased due to the expectation of others. The respondents' perception was that they, as the manager were expected to sort out the problems of everyone. In some situations this increased the manager's workload, but it also raises the question of empowerment of others. The manager often recognised that the individual should be able to find a solution, but they seemed to refer the problem to the manager. The reason for this is not evident from the data, but could be related to either an educational issue or a hierarchical issue. Based on a "role culture"

as suggested by Handy (1985) the person in a senior position could be expected to solve the problems of their subordinates. There appears to be lack of awareness and understanding of the role of the middle manager by nurses, which could be confused even more if that person is also a nurse. Whether this applies only to the nurses managed by those individuals or to other parts of the "total health care resource" was not evident from the data.

As the role of the nurse manager has changed, then the role of other staff is likely to have changed as well. With more involvement in decisions, preparation of nurses for a management role is even more necessary. Thus staff in roles below that grade need preparation. The respondents referred to internal conflict between their responsibility for the managerial decisions made and their responsibility or loyalty to nursing. The respondents often felt under-valued by and alienated from staff, especially when reporting to them the outcome of management profiles or disciplinary events. If the outcome was perceived as detrimental to nurses they felt they had been disloyal to the profession. In some cases they had opposed a decision, but felt their professional advice had been disregarded. In these circumstances maintaining the corporate position expected of them as managers was even more difficult. Education for other staff in the strategic aims and direction of the organisation and its approach may empower those staff to become more involved in the decision making process and appreciate the dilemmas. To facilitate that process the organisation needs to foster the involvement of staff at grass roots level. It may well be that in the future a large proportion of middle mangers will not be nurses, as is the case in some Trusts already, and therefore nursing

advice will need to be sought from elsewhere e.g. an appropriately qualified and experienced nurse at ward level. Nurses who are not prepared to take on this responsibility may find that resources required for effective patient care are not acknowledged through lack of professional advice.

With regard to relationships at work, most comments from the respondents related to the lack of sharing of problems and peer support. This situation could be exacerbated by the divisional structure of most NHS Trusts. The respondents no longer feel able to share anxieties and concerns with fellow nurse managers due to the competitive nature of their role, one does not want to convey difficulties within the division to those outside. This suggests that the organisational structure and climate produced by the creation of divisions is creating stress for those nurses by reducing the availability of peer support.

The organisational structure and climate resulting in the increased business orientation and associated factors and coupled with the areas identified above have been encouraged by the NHS reforms. It was evident from the literature that the role in the organisation and the relationships at work for nurses in a middle management role had the potential to initiate feelings of stress. The respondents verified this. So whilst nurses in a middle management role following the NHS reforms might be expected to have some feelings of empowerment which could reduce stress, instead they seem to have increased feeling of stress due to the increased workload, an ambiguous and

conflicting role in the structure of the organisation and lack of supportive relationships at work.

Whilst the causes of work stress did reflect the literature so did feelings and behaviours associated with stress. In both personal and work situations, feelings of being out of control, self doubt, lack of confidence and not being understood were mentioned. This in turn interfered with their work performance by interfering with their thought processes. This supports some of the literature, the emotional reaction caused by stress affects the way we think, our thought processes. (Parry 1990) Ultimately stress affected the respondents work performance which aggravated their feelings associated with stress and ability to cope, thus increasing it.

How the respondents managed stress also echoed the strategies reported in the literature. All utilised their coping skills and support networks. Some sought outside help in the form of counselling to help them cope during a personal life event. However, not one respondent had used a counselling service to resolve work stress. The main reason for this was the danger of being seen as not to be coping. For that same reason, some would not discuss the feelings of stress associated with work with their line manager. For staff to be able to express feelings of stress, particularly in relation to work, they need to work in an environment that will support them, not criticise or punish them. If stress is not acknowledged by the employees, nor acknowledged within the organisation, the organisation has no apparent reason to change. It may not even be aware stress exists at all among its employees. However, one

could argue that an individual who is experiencing stress can be recognised. The respondents all gave indications as to how they could recognise stress in others, therefore employers need to be aware of these warning signs and initiate some action. Training of supervisors and managers in the recognition of stress could be one way to achieve this. Similarly, through appraisal reviews, reasons for a change in behaviour or performance can be explored with the employee.

There is definitely a link between stress and work performance substantiated by both primary and secondary data. Stress which reduces individual work performance ultimately reduces organisation performance. The cost of that reduction in performance to the organisation can be high. Similarly the cost to the individual can be high resulting in a reduction of psychological health. The cost therefore incurred through the implementation of stress reducing strategies is balanced by the subsequent increase in productivity and employee well-being.

Strategies to reduce stress were identified by the respondents and included support groups and stress management courses. Support groups can be used to reduce stress not as means of "helping people tolerate the intolerable" (Harvey 1992), but enable them perhaps to change the situation. Debriefing, following a critical incident, is one role for support groups. Often they are led by an outside facilitator as a means for those involved to share the experiences in a safe environment. Peer support does not have to come only from those in the same discipline. Support can be obtained through team

building programmes within the division (Munro 1995). Stress management programmes are another means of offering support to staff. Pruitt (1992), found that these proved to be effective and cost efficient. Stress management programmes are generally concerned with development and improvement of coping skills. They offer role play scenarios in which to practice these skills in a safe environment. However these programmes need to be organised. A "one-off" session will not provide an individual with the opportunity to change his/her behaviour. These changes need to be practiced over a period of time. However the key issue is that they tackle symptoms rather than causes. According to the respondents, for employees to access any helping strategy proposed by the organisation needs the commitment of senior management.

Counselling was not a strategy mentioned by the respondents although it was apparent from the secondary sources that a counselling service did have a part to play in reduction of stress. The respondents suggested that a counselling service would be accessed by staff only if they believed they would not be penalised by it. The admission of stress is seen as an admission of weakness and an inability to cope by the respondents. It is from where this belief comes that it is difficult to establish. Is this the concept of organisational culture? However whilst some NHS employers have recently begun to offer counselling services in various forms, the literature is as yet limited as to the use of the service by employees. In addition there seems to be very little discussion of whether feedback is received by the organisation concerning trends associated with stress in the workplace, nor evidence that this has initiated organisational change. The argument appears to be not against the

value of a counselling service within the health service, but rather its value and cost effectiveness when it emerges as part, rather than the whole of an organisation's anti-stress strategy.

Ultimately it seems from the study that there is stress associated with working as a nurse in a middle management role within the NHS and that some of that stress can be linked with the change occurring due to the NHS reforms. A counselling service could help to reduce the feelings of stress associated with work, however, the culture of the NHS inhibits the disclosure of those feelings to the organisation by the respondents. For stress to be reduced in the NHS for those nurses, the organisation needs to look to itself, by fostering an environment which is supportive in times of change and offer stress reducing measures which will be flexible to the needs of staff within it. The feedback obtained related to themes and trends from these strategies will enable the organisation to adapt to meet the needs of its staff and ultimately its customers thereby, improving the quality of the organisation not only to the users, but also the environment for those who work within it.

The collection of both primary and secondary data has enabled an analysis to be made and conclusions to be drawn. The secondary sources did allow for some conclusions to be made initially but these were based mainly on generalisations and thus needed further exploration. What seems to be emerging from this study is this notion of organisational culture. This was not explored at any great depth within this work and now on reflection appears to be a key factor associated with stress at work warranting further

consideration. Another issue that may be of use to explore further is how does stress affect those middle managers who are not nurses? Do they have a similar reluctance to admit to stress as those who are nurses? Are they affected by the "organisational culture" or is it purely related to nurses?

An assumption was made at the beginning of the study that these nurses were stressed and the design of the interview schedule was constructed on that premise. Were they suffering feeling of stress and to what degree? Some form of stress audit may have been useful to rank order the situations that actually caused the respondents feelings of stress as a means to compare and contrast individual situations.

One cannot generalise from the findings of the fieldwork as they are only applicable to a small number of NHS employees. However this work has raised areas such as those mentioned above that could take this work forward. There is stress amongst nurses in the NHS and that stress is not talked about openly. Stress interferes with an individuals well being and their work performance. Further study which identifies what it is that prevents nurses such as those in the study from discussing stress and accessing services to reduce that stress, will not only improve the health of those concerned but also the organisation in which they work. All staff in the NHS have an effect on the care of patients either directly or indirectly. The influence of the organisation in creating an environment in which employees feel cared for and nurtured is likely to improve the quality of their work and ultimately the quality of health care.

APPENDIX 1

LIFE-CHANGE EVENTS LIST USED WITH PART 2 INTERVIEW SCHEDULE

Death of spouse
Divorce
Marital separation
Jail term
Death of close family member
Personal injury or illness
Marriage/New relationship
Fired at work
Marital reconciliation
Retirement
Change in health of family member
Pregnancy
Sexual difficulties
Gain of new family member
Business readjustment
Change in financial state
Death of close friend
Change to different lines of work
Change in number of arguments with spouse
Mortgage over £40-45,000
Foreclosure of mortgage or loan
Change in responsibilities at work
Son or daughter leaving home
Trouble with in-laws
Outstanding personal achievement
Partner begins/stops work
Begin or end school
Change in living conditions
Revision or personal habits
Trouble with boss
Change in work hours or conditions
Change in residence
Change in schools
Change in recreation
Change in church activities
Mortgage or loan less than £40-45,000
Change in sleeping habits
Change in number of family get-togethers
Change in eating habits
Vacation
Christmas
Minor violations of the law

Source : Homes T.H. and Rahe (1967) in Rice P.L. (1992 : 217)

APPENDIX 2.1

INTERVIEW SCHEDULE - PART 1

General Awareness of Stress

1. How would you describe stress?

2. Do you consider stress to be positive or negative in its effect?

3. Can you describe a situation of stress both positive and negative?

4. Can you think of someone who you consider is or was experiencing stress, how did you know?

5. Do you think life is more stressful today than 20 years ago?

6. What makes it so?

APPENDIX 2.2

INTERVIEW SCHEDULE PART 2

Personal experience of stress

1. Can you identify any situation on this list that has caused you stress?

2. Is there any situation not on this list that caused you stress?

3. Can you describe how you felt/behaved during that time?

4. How did you deal with those feelings/behaviours?

5. Did you still come to work?

(If yes to 5) 6a) Do you think your stress interfered with your work performance

(If no to 5) 6b) What reason did you give for not coming to work?

7. Did you seek help from anyone to help you cope with the stress?

(If yes to 7) 8a) What sort of help was it?

8b) How useful was it and in what way?

APPENDIX 2.3

INTERVIEW SCHEDULE PART 3

Stress at Work

1. Do you think working in the NHS is more stressful today than when you first joined?

2. What has changed to perhaps make it so?

3. What aspects of your work causes you stress?

4. What is it about these situations that make it stressful?

5. How do you recognise that work is causing you stress?

6. What do you do about it e.g. take it home?

7. Do you think the organisation recognises or acknowledges stress in its workforce?

8. Would you discuss your feelings of stress with your line manager, be it related to work or home?

9. If not, what stops you?

10. How would you like to see the organisation respond with regards to reducing stress at work?

APPENDIX 3

INTERVIEW SCHEDULE PART 3

Stress at Work

1. Do you think working in the NHS is more stressful today than when you first joined?

2. What has changed to perhaps make it so?

3. What aspects of your work causes you stress?

4. What is it about these situations that make it stressful?

5. How do you recognise that work is causing you stress?

6. What do you do about it e.g. take it home?

7. Do you think the organisation recognises or acknowledges stress in its workforce?

8. Would you discuss your feelings of stress with your line manager, be it related to work or home?

9. If not, what stops you?

10. How would you like to see the organisation respond with regards to reducing stress at work?

11. Do you think a counselling service would help?

12. Would staff use it?

13. Would you go?

14. Anything else you would like to add?

APPENDIX 4

The following style suggested by Field and Morse (1991 : 134) has been adopted when quoting from the data in the anlaysis :-

Preceding each quote will be the pseudonym of the respondent

A series of dots ..... donates a pause in the flow of speech

Explanations to illustrate or explain points, or comments made by myself have been inserted in square brackets [] as a means to keep the quotations in context e.g.

> Audrey : "Stress is too much pressure ..... The problem is when there is too much of it [stress] there are too many demands"

Any grammatical errors in the quotations have been left in but acknowledged with a "sic"

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